No. 97-303

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1997

Humana Inc. and
Humana Health Insurance of Nevada, Inc.,
Petitioners,

v.

Mary Forsyth, Marietta Cade,
Willie Andrews, Mary Lou Buehler,
Helen Staves, Randolph Bratton,
and Searle Auto Glass, Inc.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

JOINT APPENDIX

JAMES W. COLBERT, III*
O'MELVENY & MYERS LLP
400 South Hope Street
Los Angeles, CA 90071
(213) 669-6000

Of Counsel
Robert N. Eccles
Linda J. Smith
Neil K. Gilman
Jordan McCollum
O'Melveny & Myers LLP

Dennis L. Kennedy
LIONEL SAWYER & COLLINS
Counsel for Petitioner

WILL KEMP*
J. RANDALL JONES, ESQ.
HARRISON, KEMP & JONES, CHTD.
600 Bank of America Plaza
300 South Fourth Street
Las Vegas, Nevada 89101
(702) 385-6000

Of Counsel
G. ROBERT BLAKEY
Notre Dame Law School

W.B. (Bill) Markovits
MARKOVITS & GREIWE
Counsel for Respondent
*Counsel of Record

PETITION FOR CERTIORARI FILED AUGUST 18, 1997
CERTIORARI GRANTED JUNE 22, 1998

TABLE OF CONTENTS

Page

Chronological List of Relevant Docket Entries ii

Complaint JA-1

First Amended Complaint JA-78

Second Amended Complaint JA-110

Affidavit of Baron T. Youn JA-141

Affidavit of Bruce K. McClure JA-143

Affidavit of Edward Cupit JA-145

Supplemental Report of Edward Cupit JA-147

Motion for Leave to File Third Amended Complaint . JA-208

Motion for Leave to File Revised Third Amended Complaint JA-321

RELEVANT DOCKET ENTRIES

United States District Court
District of Nevada

March 29, 1989	Complaint
September 26, 1989	Order Granting in Part and Denying in Part Defendants' Motion to Dismiss, Granting Class Certification for ERISA and Antitrust Premium-Payor Claims, and Directing Plaintiffs to File and Amended Complaint
October 27, 1989	Amended Complaint
April 27, 1990	Plaintiffs' Supplemental Exhibit in Opposition to Defendant's Motion to Dismiss
July 9, 1991	Order Granting in Part and Denying in Part Defendants' Motion to Dismiss Amended Complaint, Granting Class Certification for RICO and Antitrust Co-Payor Claims, and Directing Plaintiffs to file a Seconded Amended Complaint
August 12, 1991	Second Amended Complaint
October 31, 1991	Motion for Leave to File Third Amended Complaint
December 6, 1991	Order Denying Plaintiffs' Motion for Leave to File Third Amended Complaint

Relevant Docket Entries Continued

December 13, 1991	Motion for Leave to File Revised Third Amended Complaint
February 7, 1992	Order Denying Plaintiffs' Motion for Leave to File Revised Third Amended Complaint
June 22, 1992	Defendants' Motion for Summary Judgment
July 7, 1992	Defendants' Notice of Correction to Defendants' Motion for Summary Judgment
August 7, 1992	Plaintiff's Opposition to Defendants' Motion for Summary Judgment
August 12, 1992	Erratum to Plaintiffs' Opposition to Defendants' Motion for Summary Judgment
September 30, 1992	Supplement to Plaintiffs' Opposition to Defendants' Motion for Summary Judgment
October 19, 1992	Defendants' Reply Memorandum in Support of Motion for Summary Judgment
February 22, 1993	Defendants' Supplemental Memorandum in Support of Motion for Summary Judgment
March 1, 1993	Plaintiffs' Submittal of Excerpts from Opposition to Motion for Summary Judgment

Relevant Docket Entries Continued

May 17, 1993	Plaintiffs' Third Supplement to Opposition to Motion for Summary Judgment and Plaintiffs' Response to Defendants' February 22, 1993 Supplemental Memorandum in Support of Motion for Summary Judgment
June 1, 1993	Plaintiffs' Motion for Partial Default Judgment and Supplement to Opposition to Motion for Summary Judgment
June 2, 1993	Defendants' Supplemental Memorandum in Support of Motion for Summary Judgment
June 8, 1993	Plaintiffs' Fourth Supplement to Opposition to Motion for Summary Judgment
June 23, 1993	Defendants' Third Supplemental Memorandum in Support of Motion for Summary Judgment
June 25, 1993	Plaintiffs' Response to Defendants' June 2, 1993 Supplemental Memorandum in Support of Motion for Summary Judgment and Plaintiffs' Fifth Supplement to Opposition to Motion for Summary Judgment
June 29, 1993	Defendants' Supplemental Memorandum in Support of Motion for Summary Judgment

Relevant Docket Entries Continued

June 30, 1993	Plaintiffs' Reply to Defendants' Opposition to Plaintiffs' Motion for Partial Default Judgment and Supplement to Opposition to Motion for Summary Judgment
July 1, 1993	Plaintiffs' Response to Defendants' Second and Third Supplemental Memoranda in Support of Motion for Summary Judgment
July 1, 1993	Defendants' Response to Plaintiffs' Fourth Supplement to Opposition to Motion for Summary Judgment
July 2, 1993	Defendants' Fourth Supplemental Memorandum in Support of Motion for Summary Judgment
July 21, 1993	Order Granting Defendants' Motion for Summary on all Claims and Giving Plaintiffs Until August 24, 1993 to File a Third Amended Complaint for Relief Under ERISA Claims

U.S. Court of Appeals for the Ninth Circuit

November 8, 1994	Opening Brief for Plaintiffs-Appellants
December 20, 1994	Defendants-Appellees' Answering Brief

Relevant Docket Entries Continued

January 14, 1995	Plaintiffs-Appellants' Reply Brief
March 11, 1996	Plaintiffs Appellants' Supplemental Brief Regarding *Varity Corp. v. Howe*
April 25, 1996	Defendants-Appellees' Supplemental Brief Regarding *Varity Corp. v. Howe*
May 23, 1997	Order Affirming in Part, Reversing in Part, and Remanding to District Court

J. RANDALL JONES, ESQ.
JONES, JONES, CLOSE
& BROWN, CHARTERED
700 Valley Bank Plaza
300 So. Fourth Street
Las Vegas, NV 89101-6026
Telephone: (702) 385-4202

STANLEY M. CHESLEY, ESQ.
WAITE, SCHNEIDER, BAYLESS &
CHESLEY CO., L.P.A.
1513 Central Trust Tower
Fourth and Vine Streets
Cincinnati, OH 45202

ATTORNEYS FOR PLAINTIFFS

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO. CV-S-89-249 PMP (L.R.L.)

MARY FORSYTH, ROBERT AND MARRIETTA CADE, WILLIE ANDREWS, MARY LOU BUEHLER, HELEN STAVES, RANDOLPH BRATTON, SEARLE AUTO GLASS, INC., doing business as BEST GLASS COMPANY, W. E. KRUMMEL, SR.,

Plaintiffs,

vs.

HUMANA, INC., a Delaware corporation, GROUP HEALTH INSURANCE, INC., a Delaware corporation, HUMANA HEALTH INSURANCE OF NEVADA, INC., a Nevada corporation, and DOE CORPORATIONS I through V, inclusive,

Defendants.

COMPLAINT AND JURY DEMAND

COME NOW, Plaintiffs Mary Forsyth, Robert and Marrietta Cade, Willie Andrews, Mary Lou Buehler, Helen Staves, Randolph Bratton, Searle Auto Glass, Inc., d/b/a Best Glass Co., and W. E. Krummel, Sr., by and through their counsel of record, Jones, Jones, Close & Brown, Chartered, and Waite, Schneider, Bayless & Chesley Co., L.P.A., and for their causes of action against Defendants complain, aver and allege as follows:

JURISDICTION

1. This action arises under the laws of the United States and includes claims under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001, *et seq.*, the antitrust laws of the United States, 15 U.S.C. § 1 *et seq.*, and the law of the State of Nevada. Subject matter jurisdiction in conferred upon this Court by 29 U.S.C. § 1132, 15 U.S.C. § 15, 28 U.S.C. §1237, and the doctrine of ancillary and pendent jurisdiction.

2. Venue of this action is proper in this Court pursuant to 15 U.S.C. § 15, 28 U.S.C. § 1391 and 29 U.S.C. § 1132.

BACKGROUND

3. Plaintiffs are individuals and entities utilizing health care services and/or the health insurance plan of Defendant, Humana, Inc. ("Humana"), and its wholly owned subsidiary Defendant, Humana Health Insurance of Nevada, Inc. ("Humana-Insurance"). Humana owns and operates Humana Hospital-Sunrise, an acute care facility located in Clark County, Nevada. Group Health Insurance, Inc. ("Group-Insurance") is a wholly owned subsidiary of Humana and it retains beneficial interest in 100% of the stock of Humana-Insurance. Plaintiffs and the class are suing the Defendants for the damages they sustained as a result of

the methods by which Defendants operated the health insurance plan and Humana Hospital-Sunrise. The Defendants, through a scheme of self-dealing, funneled monies from Humana Hospital-Sunrise to Humana-Insurance in order to hide excess profits being made by the hospital. Plaintiffs are demanding damages as well as declaratory relief and the imposition of a constructive trust as a result of the Defendants' wrongful conduct.

PARTIES

4. Plaintiff Mary Forsyth resides at 4625 East Twain Street, Las Vegas, Nevada 89121. In 1986 Ms. Forsyth was insured with Humana Care Plus through her employer, Kreel Printing. At Kreel Printing health insurance was optional. Some employees, like Ms. Forsyth, took insurance and some did not. In September 1986 Ms. Forsyth was hospitalized at Humana Hospital-Sunrise. In nine days of hospitalization she incurred a bill of $21,971.76. As a result of her co-payment provisions, Ms. Forsyth paid $2,300.00 out of her own pocket for that hospitalization.

5. Plaintiffs Robert and Marrietta Cade, 4433 West Lake Mead Boulevard, Las Vegas, Nevada have been insured with Humana-Insurance since 1985. Both Robert and Marrietta Cade worked for many years at the Las Vegas Sun. Mr. Cade terminated his employment with the Las Vegas Sun in late 1985 and Mrs. Cade terminated her employment in December 1988. Mr. Cade was hospitalized at Humana Hospital-Sunrise between October 7, 1987 and October 17, 1987. Mr. Cade incurred a hospital bill of $16,437.66. The Cades paid all appropriate co-payments for his hospitalization. The Cades were at all times relevant Humana-Insurance insureds and currently remain personally insured with Humana Care Plus paying a monthly premium of $355.00 per month.

6. Plaintiff Willie Andrews, 804 McWilliams Street, Las Vegas, Nevada 89106, has been insured with Humana Care Plus since May 1985. Mr. Andrews was hospitalized from November 4, 1986 through November 9, 1986. At all times relevant Mr. Andrews was employed with the Clark County School District. Mr. Andrews, under his co-pay provisions, was obligated to pay a percentage of all of his hospitalization costs as well as the premium payments paid by him through his employer.

7. Plaintiff Mary Lou Buehler, 210 Meyers Avenue, Henderson, Nevada 89015, has been insured with Humana-Insurance since 1984. She is insured through her husband's employer, Cashman Cadillac. Through her husband an optional premium is paid of approximately $140.00 per month for her coverage as a dependent. In September 1987 and again in October of 1988 Mrs. Buehler was hospitalized for a total of approximately fourteen days. Her billings for those hospitalizations were $23,293.94 and $2,736.85, respectively. Under the co-payment provision of her policy, she was obligated to pay 20% of the costs of her hospitalization, over and above the premium payments.

8. Plaintiff Helen Staves, 37 East Stewart, Unit 50, Las Vegas, Nevada 89110, has been insured with Humana-Insurance since July 1988. In December 1988 Ms. Staves was hospitalized at Humana Hospital-Sunrise. Pursuant to the co-payment provisions under her policy, she is required to pay 20% of the costs of that hospitalization. Her expenses incurred for that hospitalization were $14,764.25. At all times relevant, Mrs. Staves was employed at the Dunes Hotel and made separate monthly premium payments of $40.00 per pay period for her policy of health insurance with Humana-Insurance.

9. Plaintiff Randolph Bratton, P.O. Box 175, State Route 38, Las Vegas, Nevada 89124 has been insured with

Humana-Insurance since 1985. Between 1985 and August of 1987, Mr. Bratton was employed by the Las Vegas Sun. Since August 1987, Mr. Bratton has been employed by the Clark County School District. Mr. Bratton remains in the employ of Clark County School District to this date. At all times relevant, Mr. Bratton was an insured of Humana-Insurance. On February 12, 1988, Mr. Bratton was admitted to Humana Hospital-Sunrise. At that time, day surgery was performed and he incurred a hospital bill of approximately $1,400.00. Mr. Bratton remains obligated on that amount as Humana-Insurance has denied the claim of payment as a pre-existing condition.

10. Plaintiff Searle Auto Glass, Inc., doing business as Best Glass Co. ("Best Glass"), 1225 S. Commerce Street, Las Vegas, Nevada 89102, is a Nevada corporation in good standing. Best Glass has utilized Humana-Insurance to provide health insurance to its employees between the years 1985 and 1988, inclusive. Best Glass group number with Humana-Insurance is 82801-18351-001. When Best Glass first became an insured with Humana-Insurance, the rates were very reasonable, $64.23 per employee per billing period. In 1986 this rate increased by 3% and in 1987 the rate jumped 13%. Finally, when Best Glass decided not to renew with Humana-Insurance, it sought a premium increase of 41% to continue coverage of employees of Best Glass. At no time did Humana-Insurance ever inform Best Glass that it was able to negotiate favorable hospitalization rates for its employees using Humana Hospital-Sunrise for hospitalizations.

11. Plaintiff W. E. Krummel, Sr., 1225 S. Commerce Street, Las Vegas, Nevada 89102, was an insured with Humana-Insurance and an employee of Best Glass between 1985 and 1988, inclusive.

12. The named Plaintiffs are: employers who have provided insurance to their employees through Humana-Insurance, insureds of Humana-Insurance, claimants under the health insurance policies issued by Humana-Insurance (''Humana Care Plus''), and individuals who have utilized the health care services of Humana.

13. Defendant Humana-Insurance is a Nevada corporation in good standing conducting business in the County of Clark, State of Nevada and is a wholly owned subsidiary of Humana (through Group-Health).

14. ''Group-Insurance'' is a Delaware corporation holding beneficial interest in all of the stock of Humana-Insurance and is itself a wholly owned subsidiary of Humana.

15. Defendant Humana is a Kentucky corporation licensed to do business in the State of Nevada.

16. The true names and capacities, whether individual, corporate, associate, or otherwise, of Defendants herein designated as DOE CORPORATIONS I through V, inclusive, are unknown to Plaintiffs at this time, who therefore sue said Defendants by such fictitious names. Plaintiffs are informed and believe and thereon allege that each of said Defendants is responsible in some manner for the events and happenings and proximately caused the injuries and damages herein alleged. Plaintiffs will seek leave to amend this Complaint to allege their true names and capacities when and as ascertained.

CLASS ACTION ALLEGATIONS

17. This section is brought by Plaintiffs as a class action on their own behalf and on behalf of the following classes and all others similarly situated, under the provisions of Rule 23(a) and Rule 23(b)(1)(B), (2) and (3) of the Federal Rules of Civil Procedure, for damages, equitable relief and declaratory relief, including costs and attorneys' fees.

(a) A class consisting of employers and individuals contracting with Humana-Insurance and paying premiums on behalf of themselves and/or their employees; and

(b) A class consisting of individuals who were hospitalized at Humana Hospital-Sunrise and who were insured with Humana-Insurance.

18. The classes are represented by Plaintiffs in this action of which Plaintiffs are themselves members, and consist of all those insured by Humana-Insurance and/or or who received inpatient hospitalization at Humana Hospital-Sunrise and/or who made premium payments to Humana-Insurance at all times relevant hereto.

19. The members of the class of Plaintiffs are so numerous that joinder is impractical. The exact number of the members of the class is unknown to Plaintiffs, but may be determined from records maintained by Defendants Humana and Humana-Insurance. It is estimated that there may be tens of thousands of plaintiffs. In many instances the members of the class are unaware that claims exist or are about to be brought, or are unaware of the facts giving rise to such claims, or having knowledge of such claims, or having knowledge of such claims, had, in many instances, sustained damages in such an amount that when taken individually are too small to justify the enormous expense and effort required to sue separately. Nevertheless, the damages and class members as a group are substantial and significant to justify the taking of legal action.

20. There are common questions of law and fact in the action that relate to and affect the rights of each member of the class and the relief sought in common to the entire class. Each Plaintiff asserts that Humana and Humana-Insurance in 1985, 1986, 1987 and 1988 operated a scheme to unlawfully

and/or inequitably profit from hospitalizations at Humana Hospital-Sunrise.

21. This action is properly maintained as a class action inasmuch as the questions of law and fact common to all members of the class predominate over any questions affecting only individual members, and the class action is superior to other available methods for the fair and efficient adjudication of this controversy. Among the questions of law or fact common to the classes are the following:

(a) Whether Defendants breached their contractual obligations to Plaintiffs to provide hospital services at a reasonable price?

(b) Whether Humana-Insurance breached its obligation to its Plaintiff insureds to pass along reduced costs in the form of reduced premiums?

(c) Whether Defendants participated in a scheme to unlawfully and/or inequitably funnel monies from Humana to Humana-Insurance in 1987 and 1988 in violation of state law and in breach of their obligations to plaintiffs?

(d) Whether Defendants unlawfully and/or inequitably failed to reduce co-payments and deductible payments of plaintiffs for hospitalizations at Humana-Sunrise?

(e) Whether Defendants by their conduct violated federal and state antitrust laws?

(f) Whether Defendants have been unjustly enriched by the scheme described herein?

(g) Whether Plaintiffs and the class have been damaged and the extent of those damages?

22. The claims of Plaintiffs, who are represented as of the class herein, are typical of the claims of the class, in that the

claims of all members of the class, including Plaintiffs, depend upon a showing of the acts and omissions of Defendants giving rise to the right of Plaintiffs to the relief sought herein.

23. The named Plaintiffs are the representative parties for the class, and are able to, and will, fairly and adequately protect the interest of the class. The attorneys for Plaintiffs are experienced and knowledgeable in the field and have successfully represented claimants in other litigation.

24. This action is properly maintained as a class action under Fed. R. Civ. P. 23(b)(1)(B) because prosecution of separate actions by individual members of the class would create a risk of adjudications with respect to individual members of the class that would, as a practical matter, dispose of the interest of the other members not parties to the adjudications, or which substantially impair or impede their ability to protect their interests.

25. This action is properly maintained as a class action under FRCP 23(b)(2) inasmuch as the Defendants, all of whom oppose the class, have acted or refused to act, as herein more specifically allege, on grounds which are applicable to the class and have by reason of such conduct, made appropriate final equitable relief and declaratory relief with respect to the entire class, as sought in this action.

FIRST CLAIM FOR RELIEF

(Breach of ERISA Fiduciary Duties)

26. Plaintiffs reassert and reallege each and every allegation contained in paragraphs 1 through 25 of the Complaint as though fully set forth at this point.

27. Many of the members of the class are employers or employees obtaining or providing health insurance benefits under an employee benefit plan as defined under 29 U.S.C. 1001, *et seq*.

28. Defendant Humana-Insurance is the insurer of a class of Plaintiffs through its insurance plan, Humana Care Plus. Under the Humana Care Plus policy, Humana-Insurance has fiduciary duties to Plaintiffs who fall under ERISA protection. 29 U.S.C. §§ 1104 and 1105.

29. Under 29 U.S.C. 1001, *et seq.*, Humana and Humana-Insurance, as fiduciaries of Plaintiffs, have a duty to provide health insurance at a reasonable cost.

30. Humana and Humana-Insurance entered into an agreement to reduce hospitalization costs for Humana-Insurance plaintiffs.

31. Defendant Humana-Insurance has breached its fiduciary duties to all Plaintiffs protected by ERISA in that it has failed to pass along the reduced costs it was able to negotiate with Humana in the form of reduced premiums and co-payments.

32. Plaintiffs have been damaged as a result of the breach of its fiduciary duties by Humana and Humana-Insurance.

33. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered and Waite, Schneider, Bayless & Chesley Co., L.P.A. to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor. 29 U.S.C. § 1132(g).

SECOND CLAIM FOR RELIEF

(Constructive Trust)

34. Plaintiffs reassert and reallege each and every allegation contained in paragraphs 1 through 25 of the Complaint as though fully set forth at this point.

35. The Defendants have retained profits in excess of $10,000,000.00 as a result of the scheme described herein.

36. Such monies were unlawfully obtained in contravention of Assembly Bill 289, as passed by the 1987 Nevada Legislature and signed into law by the Governor of the State of Nevada ("AB 289"), and further are in violation of the Defendants' duties to the Plaintiffs. 29 U.S.C. 1001, *et seq.*

37. It would be wrongful for Humana and Humana-Insurance to retain monies, in excess of those they might otherwise have been entitled to, when such monies have been obtained through the breach of federal and state law and Humana-Insurance agreement with Plaintiffs.

38. A constructive trust should be imposed on the Defendants which requires turnover of all monies obtained through the scheme described herein.

39. Plaintiffs should be named the beneficiaries of the constructive trust awarded by this Court.

40. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered and Waite, Schneider, Bayless & Chesley Co., L.P.A. to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor.

THIRD CLAIM FOR BELIEF

(Breach of Contract)

41. Plaintiffs reassert and reallege each and every allegation contained in Paragraphs 1 through 25 of the General Allegations.

42. Defendant Humana-Insurance is the insurer of a class of Plaintiffs through its insurance plan, Humana Care Plus. Under the Humana Care Plus policy and the laws of the State of Nevada, Humana-Insurance is obligated to pass along reduced costs to its insureds in the form of reduced premiums.

43. Humana and Humana-Insurance entered into an agreement to reduce hospitalization costs for Humana-Insurance plaintiffs.

44. Defendant Humana-Insurance has breached its obligation to Plaintiffs under the Humana Care Plus policy in that it has failed to pass along the reduced costs it was able to negotiate with Humana in the form of reduced premiums.

45. Defendant Humana-Insurance has breached its agreement with Plaintiffs causing damages in the form of increased premiums and excessive co-payments paid during hospitalization stays at Humana Hospital-Sunrise.

46. As a result of defendants breach Plaintiffs have suffered damages in excess of $10,000,000.00.

47. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered and Waite, Schneider, Bayless & Chesley Co., L.P.A. to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor.

FOURTH CLAIM FOR RELIEF

(Unfair Claims Practices)

48. Plaintiffs reassert and reallege each and every allegation contained in Paragraphs 1 through 46 of the Complaint as though fully set forth at this point.

49. Humana-Insurance is engaged in the business of insurance in the State of Nevada and policies of insurance were issued and delivered to Plaintiffs and the members of the class were employees or insureds within the State of Nevada.

50. Humana-Insurance committed the following acts in violation of the Nevada Unfair Claims Practices Act, 686A.310 in that it:

(a) Failed to pass along premium reductions to their insureds;

(b) Failed to properly process claims of its insureds;

(c) Failed to notify insureds that they had overpaid their co-payments and deductibles; and

(d) Failed to make prompt and reasonable settlements of all claims presented.

51. The above acts constitute violations of HRS 686A.310 and there is a private right of action for all such acts committed in 1987 and 1988.

52. Plaintiffs and the members of the class have suffered damages in an amount in excess of $10,000,000.00.

53. It has been necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered and Waite, Schneider, Bayless & Chesley Co., L.P.A. to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor.

FIFTH CLAIM FOR RELIEF

(Breach of the Implied Covenant of Good Faith and Fair Dealings)

54. Plaintiffs reassert and reallege each and every allegation contained in Paragraphs 1 through 52 of the Complaint as though fully set forth at this point.

55. Implied in the Humana-Insurance health insurance policies with Plaintiffs is the covenant of good faith and fair dealings governing its conduct with Plaintiffs.

56. Humana-Insurance has breached the covenant of good faith and fair dealings in that it has failed to properly handle the claims of Plaintiffs and notify Plaintiffs of reduced premiums and cost savings that were agreed to by its parent corporation, Humana.

57. Humana-Insurance's conduct as described herein is willful, wanton, malicious and/or is in conscious reckless disregard for the rights or Plaintiffs, its insureds.

58. As the proximate result of the conduct of Humana-Insurance, Plaintiffs have been damaged generally and specially in an amount in excess of $10,000,000.00 and are entitled to punitive damages.

59. It has been necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered and Waite, Schneider, Bayless & Chesley Co., L.P.A. to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor.

SIXTH CLAIM FOR RELIEF

(Anti Trust)

60. Plaintiffs reassert and reallege each and every allegation contained in paragraphs 1 through 25 of the Complaint as though fully set forth at this point.

61. Defendants Humana and Humana-Insurance provided services within the State of Nevada, County of Clark, to Plaintiffs. Defendants are also engaged in the business of interstate commerce. Defendants offer their services both to in-state and out-of-state patients and/or insureds.

62. Humana-Insurance, although a wholly owned subsidiary of Group-Health, which in turn is wholly owned by Humana, was at all times relevant hereto treated as an independent and separate entity by Humana, and entered into an arm's length agreement with Humana. Humana and Humana-Insurance conspired to operate a scheme which includes the following components:

(a) Initially offering extremely low premium rates for the Humana Care Plus policy with the intention of dramatically increasing those rates once market penetration was obtained;

(b) Requiring extensive penalities for Plaintiffs who failed to utilize the services of the only "preferred provider hospital" in the Southern Nevada area, Humana Hospital-Sunrise;

(c) Creating a boycott of all other acute care providers (by effectively forcing all Humana-Insurance insureds to be treated at Humana Hospital-Sunrise) in the Southern Nevada area for insureds of Humana-Insurance.

63. Defendants, by operating the scheme described herein, have implemented a system designed in the long-term to reduce or eliminate price competition within the greater Las Vegas metropolitan area.

64. Defendants' scheme of predatory pricing and boycotting along with the other activities described herein constitutes a conspiracy which is intended to and does in fact unreasonably restrain trade and commerce in the relevant geographic market in violation of 15 U.S.C. §§ 1 and 2 and HRS 598A.910, *et seq.*, all to the damage and detriment of Plaintiffs.

65. Plaintiffs are entitled to receive costs of suit and reasonable attorneys' fees and Plaintiffs' damages are to be trebled for the conduct described herein. 15 U.S.C. § 15.

SEVENTH CLAIM FOR RELIEF

(Unjust Enrichment)

66. Plaintiffs reassert and reallege each and every allegation contained in paragraph 1 through 64 of the Complaint as though fully set forth at this point.

67. As a result of the Defendants' unlawful, and/or inequitable scheme heretofore alleged, Plaintiffs conferred a monetary benefit upon the Defendants. Defendants appreciated and realized the monetary benefit and Defendants accepted and retained the monetary benefit under circum-

stances such that it would be inequitable for the Defendants to retain the monetary benefit without returning the benefit to Plaintiffs. As a result of the scheme, the Defendants were unjustly enriched.

68. As a direct and proximate result of the unjust enrichment, Plaintiffs have suffered damages in an amount in excess of $10,000,000.00.

69. It has been necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered and Waite, Schneider, Bayless & Chesley Co., L.P.A. to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor.

EIGHTH CLAIM FOR RELIEF

(Declaratory Relief)

70. Plaintiffs reassert and reallege each and every allegation contained in paragraphs 1 through 25 of the Complaint as though fully set forth at this point.

71. A declaratory judgment pursuant to Rule 57 of the Federal Rules of Civil Procedure and 28 U.S.C. § 2201, as well as NRCP 57, therefore, is needed to judicially declare the rights of Plaintiffs and all class members under the Humana-Insurance policy, to prevent further abuses that threaten Plaintiffs and all class members' ability to obtain medical insurance at reasonable premiums and to pay reasonable co-payments, where applicable.

WHEREFORE, Plaintiffs pray for judgment against Defendants, jointly and/or severally, where applicable in each claim for relief as follows:

1. An amount in excess of $10,000,000.00 on the First Claim for Relief.

2. A constructive trust to be imposed upon the Defendants in the amount of all monies received as a result of the

scheme, with Plaintiffs to be named as the beneficiaries of the trust on the Second Claim for Relief.

3. An amount in excess of $10,000,000.00 on the Third Claim for Relief.

4. For general, special, compensatory and punitive damages in the amount in excess of $10,000,000.00 on the Fourth Claim for Relief.

5. For general, special, compensatory and punitive damages in the amount in excess of $10,000,000.00 on the Fifth Claim for Relief.

6. For general, special, compensatory and punitive damages in the amount in excess of $10,000,000.00 on the Sixth Claim for Relief.

7. An amount in excess of $10,000,000.00 on the Seventh Claim for Relief.

9. For judgment by this court establishing the rights and duties between the parties and for judgment requiring Defendant to cease and desist from the wrongful conduct described in the Complaint on the Eighth Claim for Relief.

10. For costs of suit and fees incurred herein.

11. For such further and other relief as the Court deems just and equitable.

DATED this 29th day of March, 1989.

/s/ J. Randall Jones
J. RANDALL JONES, ESQ.
JONES, JONES, CLOSE & BROWN, CHARTERED
300 So. Fourth St., #700
Las Vegas, Nevada 89101

/s/ Stanley M. Chesley
STANLEY M. CHESLEY, ESQ.
WAITE, SCHNEIDER, BAYLESS & CHESLEY CO., L.P.A.
1513 Central Trust Tower
Fourth & Vine Streets
Cincinnati, Ohio 45202

ATTORNEYS FOR PLAINTIFFS

JURY DEMAND

Plaintiffs demand a trial by jury on all issues so triable.

/s/ J. Randall Jones
J. RANDALL JONES, ESQ.
JONES, JONES, CLOSE & BROWN, CHARTERED
300 So. Fourth St., #700
Las Vegas, Nevada 89101

/s/ Stanley M. Chesley
STANLEY M. CHESLEY, ESQ.
WAITE, SCHNEIDER, BAYLESS & CHESLEY CO., L.P.A.
1513 Central Trust Tower
Fourth & Vine Streets
Cincinnati, Ohio 45202

ATTORNEYS FOR PLAINTIFFS

[Letterhead of LIONEL SAWYER & COLLINS]
[Las Vegas, Nevada]

TELECOPY TRANSMITTAL FORM

DATE: 4-18-89
TO: Tom Brock
FIRM: Casson, Harkins & LaPallo FAX # (202) 338-1479
FROM: Dennis Kennedy TIME 11:12 A.M. FILE # 3814-105
Number of Pages (including cover page) 29
Description of Material: _____

_____

_____

_____

IF NOT PROPERLY RECEIVED, PLEASE CALL:

_____ at (702)383-8850 or 383-8892 (telecopy center) or
_____ (Secretary) at (702) 383-_____

CONFIRMATION #: (202) 778-1100

CERTIFICATE OF SERVICE

I hereby certify that on this 15th day of June, 1987, I caused a copy of the foregoing to be served via first class mail, postage prepaid, to:

Gary D. Greenwald, Trial Attorney
Schottenstein, Zox and Dunn
41 S. High Street
Columbus, Ohio 43215

---

tyw:004-72Cons

NEVADA
COMPREHENSIVE
CONTRACT
REVISED
9/26/84

3201 South Maryland Parkway
Las Vegas, Nevada 89109

HUMANA CARE PLUS
HUMANA HEALTH INSURANCE COMPANY
OF NEVADA, INC.

This policy contains the terms under which the Insurance Company agrees to insure certain Employees and pay benefits.

The Insurance Company and the Policyholder have agreed to all of the terms of this policy.

THIS POLICY CONTAINS A DEDUCTIBLE

Secretary
/s/ Alise F. Newton

President
/s/ Henry J. Wenonen

[HCP-84-NV-1]

CONTENTS

SECTION

1. Front Page
2. Contents
3. Schedule
4. Definitions
5. Eligibility for Insurance
6. Effective Date for Insurance
7. Insuring Provisions
8. General Limitations
9. Medicare Eligibles
10. Co-ordination of Benefits
11. Payment of Benefits

12. Termination of Insurance
13. Medical Benefits Extension
14. Medical Conversion Privilege
15. Provisions
16. Cancellation of Policy; Grace Period
17. Provisions; Certificate; Claim Forms and Notice of Claim

[Section 2 2-1]

POLICYHOLDER: SAHARA & HACIENDA HOTELS

ADDRESS: P.O. BOX 18437
LAS VEGAS, NEVADA 89114

POLICY NUMBER: 78274

EFFECTIVE DATE: FEBRUARY 1, 1985

ANNIVERSARY DATE: FEBRUARY 1

HUMANA CARE PLUS
GROUP COMPREHENSIVE MEDICAL EXPENSE INSURANCE POLICY

[HCP-84-NV-1]

INDIVIDUAL MAXIMUM LIFETIME BENEFIT	$1,000,000
CALENDAR YEAR DEDUCTIBLE EACH PERSON	$200
CALENDAR YEAR DEDUCTIBLE EACH FAMILY	$400
HOSPITAL BENEFIT	
—Participating Hospital Room and Board and Other Services	90% of Semi-Private

—Non-Participating Hospital Room and Board and Other Services	70% of Semi-Private
Deductible Each Admission	$1,200
BENEFIT PERCENTAGE FOR OTHER MEDICAL SERVICES (Except Where Provided Otherwise)	80%
PERSONAL EXPENSE LIMIT BY EACH INSURED FOR COVERED CHARGES IN A CALENDAR YEAR*	$1,000
PERSONAL EXPENSE LIMIT BY EACH FAMILY FOR COVERED CHARGES IN A CALENDAR YEAR*	$2,000
MENTAL AND NERVOUS DISORDER BENEFIT	
In-Patient — Hospital Maximum Calendar Year	30 days
Out-Patient — Maximum Covered Expense Calendar Year	$1,000
ALCOHOLISM AND DRUG ABUSE COURSE OF TREATMENT	
Detoxification — Maximum Days Calendar Year	7
In-Patient Maximum Covered Expense Calendar Year	$10,000
Out-Patient — Maximum Covered Expense Calendar Year	$1,500
Lifetime Maximum Courses of Treatment	3
SPECIALTY CARE FACILITY BENEFIT	
Calendar Year Maximum	60 days

HOME HEALTH CARE SERVICES

Maximum Visits Calendar Year 40

PRE-EXISTING CONDITION BENEFIT MAXIMUM

Maximum Expense $2,000

SUPPLEMENTAL ACCIDENT BENEFIT $500

*Does Not Include Deductibles

[Section 3 (NV-Rev. 8-84) 3-1]

Deductible for any person or family will be reduced to the extent that the Comprehensive Medical Deductible for the prior calendar year was deducted from Covered Expenses incurred for that person during October, November, and December of such year.

[Section 3 3-2]

ACTIVE SERVICE. An Employee will be considered in Active Service with the Employer on a day which is one of the Employer's scheduled work days if he is performing in the usual way all of the regular duties of his work for the Employer on a full-time basis on that day, either at one of the Employer's places of business or at some location to which the Employer's business requires him to travel. An Employee will be deemed in Active Service on a day which is not one of the Employer's scheduled work days only if he was in Active Service on the preceding schedule work days.

COVERED CHARGES OR COVERED EXPENSES. The terms mean charges or expenses incurred for medical care to the extent they are covered by this policy and for which benefits are payable.

EMPLOYEE. The term Employee means a full-time employee of the Employer, but does not include employees

who are part-time or temporary or who normally work less than 20 hours a week for the Employer.

EMPLOYER. The term Employer means the Policyholder and all Affiliated Employers shown in the "Eligibility for Insurance" section.

[Section 4 (NV-Rev. 8-34) 4-1]

DEPENDENT. The term Dependent means:

(1) the lawful spouse of the Employee; and

(2) any unmarried child who is

(a) less than 19 years old;

(b) 19 years but less than 25 years old, enrolled in a school as a full-time student and primarily supported by the Employee;

(c) 19 or more years old and primarily supported by the Employee and incapable of self-sustaining employment by reason of mental or physical handicap. At the time of claim under the policy for a child who is handicapped as defined in this paragraph, the policyholder must submit proof to the Insurance Company that the child is and has continued to be handicapped as defined by this paragraph.

The term child means a child born to the Employee and a child legally adopted by the Employee. It also means a step-child of the Employee living with the Employee.

Anyone who is eligible for the insurance as an Employee will not be considered as a Dependent.

No one may be considered as a dependent of more than one Employee.

[Section 4 4-2]

HOSPITAL CONFINEMENT OF CONFINED IN A HOSPITAL. A person will be considered confined in a Hospital if he is:

(1) a registered bed patient in a hospital upon the recommendation of a Physician;

(2) an out-patient in a hospital because of surgery; or

(3) receiving emergency care in a hospital for an Injury on his first visit as an out-patient within 72 hours after the Injury is received.

HOSPITAL. The term Hospital means:

(1) an institution licensed as a hospital, which:

(a) maintains, on the premises, all facilities necessary for medical and surgical treatment; and facilities controlled by the hospital;

(b) provides such treatment on an in-patient basis, for compensation, under the supervision of Physicians; and

(c) provides 24-hour service by Registered Graduate Nurses; or

(2) an institution which qualifies as a hospital, a psychiatric hospital, a tuberculosis hospital, a provider of rehabilitative services and a provider of services under Medicare, if such institutions is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals, the American Osteopathic Hospital Association, or the Commission on the Accreditation of Rehabilitative Facilities.

(3) an Ambulatory Surgical Center.

The term Hospital will not include:

(a) an institution which is primarily a place for rest, a place for the aged, a place for the treatment of alcohol or drug abuse, or a nursing home;

(b) any part or unit of a hospital which qualifies as a convalescent hospital.

[Section 4 4-3]

PARTICIPATING HOSPITAL. The term Participating Hospital means a hospital which has signed a participation agreement with the Insurance Company. A complete list of Participating Hospitals will be provided to each covered employee by the Insurance Company.

AMBULATORY SURGICAL CENTER. The term Ambulatory Surgical Center means a licensed public or private institution which:

(1) is operated by Physicians and a medical staff including Registered Graduate Nurses;

(2) has permanent facilities equipped and operated primarily for performing Surgical Procedures; and

(3) provides continuous Physician services on an out-patient basis.

BED AND BOARD. The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients. Charges for Bed and Board up to the hospital's semi-private room rate will qualify as Covered Expenses.

NECESSARY SERVICES AND SUPPLIES. The term Necessary Services and Supplies refers to services and supplies ordered by a Physician and customarily recognized in the Physician's profession as appropriate in the treatment of the patient's diagnosed sickness or injury. It includes:

(1) any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement;

(2) any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and

(3) any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

PARTIAL HOSPITALIZATION SERVICES. The term Partial Hospitalization Services is defined as those services offered by a program accredited by the Joint Commission on Accreditation of Hospitals or in compliance with equivalent standards. Alcohol rehabilitation programs accredited by the Joint Commission on Accreditation of Hospitals or approved by the state and licensed drug abuse rehabilitation programs shall also be considered Partial Hospitalization Services.

NURSE. The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.", "L.P.H.", or "L.V.N.".

PERSONAL EXPENSE LIMIT. The personal expense limit is the amount of Covered Medical expense that must be paid by each person or family in a calendar year.

PHYSICIAN. The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to

perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

(1) operating within the scope of his license; and

(2) performing a service for which benefits are provided under this plan when performed by a Physician.

PSYCHOLOGIST. The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include another licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

(1) operating within the scope of his license; and

(2) performing a service for which benefits are provided under this plan when performed by a Psychologist.

(Continued)

SPECIAL CARE FACILITY. The term Special Care Facility means a licensed institution (other than a Hospital, as defined) which:

(1) specializes in physical rehabilitation;

(2) qualifies as a skilled nursing facility and a provider of services under Medicare;

but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

MEDICAID. The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

MEDICARE. The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

REASONABLE AND CUSTOMARY CHARGE. A charge will be considered Reasonable and a Customary if: (1) it is the normal charge made by the provider for a similar service or supply; and (2) it does not exceed the normal charge made by most providers of such service or supply in the locality where the service or supply is received. To determine if a charge is Reasonable and Customary, the nature and severity of the Injury or Sickness being treated will be considered.

EXPENSES INCURRED. An expense is incurred when the service or the supply for which it is incurred is provided.

INJURY. The term Injury means an accidental bodily injury.

SICKNESS. The term Sickness means a disease or illness, including pregnancy and complications of pregnancy, alcoholism, drug abuse, mental or nervous disorders and medical complications arising from an abortion.

(Continued)

HOME HEALTH CARE PLAN. The term Home Health Care Plan means a plan for care and treatment of a person in his home. To qualify, the plan must be established and approved in writing by a Physician who certifies that the person would require confinement in a Hospital or Skilled Nursing Facility if he did not have the care and treatment stated in the plan.

HOME HEALTH CARE AGENCY. The term Home Health Care Agency means a Hospital or a non-profit or public home health care agency which:

(1) primarily provides skilled nursing service and other therapeutic service under the supervision of a Physician or a Registered Graduate Nurse;

(2) is run according to rules established by a group of professional persons;

(3) maintains clinical records on all patients;

(4) does not primarily provide custodial care or care and treatment of the mentally ill;

but only if, in those jurisdictions where licensure by statute exists, that Home Health Care Agency is licensed and run according to the laws that pertain to agencies which provide home health care.

HOME HEALTH AIDE. The term Home Health Aide means a person who: (a) provides care of a medical or therapeutic nature; and (b) reports to and is under the direct supervision of a Home Health Care Agency.

EMPLOYEE INSURANCE ELIGIBILITY

Each Employee in one of the Classes of Eligible Employees shown below will become eligible for Employee Insurance on the day he completes the Waiting Period, if any. Any Employee who was previously insured and whose insurance ceased must satisfy the New Employee Group Waiting Period to become insured again. If the Insurance on an Employee ceased because he was no longer employed in a Class of Eligible Employees, he is not required to satisfy any Waiting Period if he again becomes a member of a Class of Eligible Employees within one year after his insurance ceased.

INITIAL EMPLOYEE GROUP. The Initial employee Group is made up of Employees: (1) in the employ of an Employer on the Effective Date of the policy; and (2) were insured under the group medical plan, if any, which was in effect on the day immediately preceding the effective day of this plan; or (3) in the employ of an Employer on the date that Employer becomes an Affiliated Employer.

NEW EMPLOYEE GROUP. The New Employee Group is made up of Employees not in the Initial Employee Group.

WAITING PERIOD

Initial Employee Group:	None
New Employee of the Group:	Ninety (90) days of full-time employment

AFFILIATED EMPLOYERS

Resorts Marketing, Inc.
Sahara Resorts, Inc.

CLASSES OF ELIGIBLE EMPLOYEES

All full-time Non-union Employees

[Section 5 (NV-Rev. 8-84) 5-1]

Each Employee will become eligible for Dependent Insurance on the latest date below:

(1) the date he becomes eligible for Employee Insurance;

(2) the date he acquires his first Dependent;

(3) the effective date of Dependent Insurance.

[Section 5 5-2]

Each Employee may elect to be insured for Employee Insurance only by signing a payroll deduction form approved by the Policyholder and the Insurance Company. The effective

date of his insurance depends upon the date on which the Employee elects the insurance.

(1) If he elects Employee Insurance on or before the date he becomes eligible, his insurance will become effective on the first day of the month after he becomes eligible.

(2) If he elects Employee Insurance within 31 days after he becomes eligible, his insurance will become effective on the first day of the month after he becomes eligible or on the date of election, whichever is later.

(3) If he elects Employee Insurance more than 31 days after he becomes eligible, his insurance will become effective on the date the Insurance Company agrees in writing to insure him.

(4) If his Employee Insurance ceased because he cancelled his payroll deduction, and he again elects to be insured, his insurance will become effective on the date the Insurance Company agrees in writing to insure him.

Under the circumstances described in items 3 and 4, the Insurance Company may require the Employee to submit evidence of good health acceptable to the Insurance Company at his own expense before it agrees to insure him.

If an Employee is not in Active Service on the date his insurance would otherwise become effective, it will become effective on the date he returns to Active Service.

[Section 6 6-1]

Each Employee may elect to be insured for Dependent Insurance only by signing a payroll deduction form approved by the Policyholder and the Insurance Company. The effec-

tive date of insurance for each Dependent depends upon the date on which the Employee elects Dependent Insurance.

(1) If the Employee elects Dependent Insurance on or before the date he becomes eligible for it, the insurance for each Dependent will become effective on the first day of the month after the Employee becomes eligible for it.

(2) If the Employee elects Dependent Insurance within 31 days after he becomes eligible for it, the insurance for each Dependent will become effective on the first day of the month after he becomes eligible or on the date of election, whichever is later.

(3) If the Employee elects Dependent Insurance more than 31 days after he becomes eligible for it, the insurance for each Dependent will become effective on the date the Insurance Company agrees in writing to insure the Dependent.

(4) If the Employee's Dependent Insurance ceased because he cancelled his payroll deduction, and he again elects to be insured for it, the insurance for each Dependent will become effective on the date the Insurance Company agrees in writing to insure the Dependent.

Under the circumstances described in items 3 and 4, the Insurance Company may require the Employee, at his own expense, to submit evidence of the Dependent's good health before it agrees to insure the Dependent.

If a Dependent is a patient in a Hospital on the date his insurance would otherwise become effective, the effective date of his insurance will be postponed until the day after he is discharged from the Hospital.

An Employee will be insured for Dependent Insurance only if he is insured for Employee Insurance.

Any reference to an insured Dependent means a Dependent for whom the Employee is insured.

EXCEPTIONS FOR NEWBORNS. Any Dependent child born while the Employee is insured for Dependent Insurance will be insured from the date of birth. A Dependent child born while the Employee is insured for himself, but not for his Dependents, will become insured on the date of the child's birth, if the Employee elects Dependent Insurance no later than 31 days after the child's birth.

[Section 6 6-2]

For Employees and Dependents

COMPREHENSIVE MEDICAL BENEFITS

If an Employee or a Dependent incurs Covered Expenses while insured for Comprehensive Medical Benefits under this policy, the Insurance Company will pay benefits as follows, subject to the Benefit Maximums, Co-payment and after any Deductible shown in the Schedule:

(a) [80%] of all Covered Expenses incurred, except that if such Covered Expenses are incurred in a Participating Hospital, the Insurance Company will pay [90%] of those Covered Expenses. If such Covered Expenses are incurred in a Non-Participating Hospital, the Insurance Company will pay [70%] of those Covered Expenses; however,

(b) the Non-Participating Hospital Deductible shown in the Schedule will first be deducted from such Covered Expenses for each admission or outpatient surgical visit in a Non-Participating Hospital and is exclusive of any Personal Expense Limit provisions; except

(c) when an amount equal to the Calendar Year Deductible for each person, if any, has been satisfied in a calendar year, the difference between the Calendar

Year and Non-Participating Hospital Deductibles will be deducted for each admission or outpatient surgical visit in a Non-Participating Hospital and is exclusive of any Personal Expense Limit provisions.

FULL PAYMENT AREA FOR COVERED EXPENSE INCURRED. After a covered person has incurred [$1,000] of expense for covered charges or a family has incurred [$3,000] expense for covered charges during a calendar year, excluding expenses used to satisfy the deductible provisions of the policy, benefits for that person or family will be paid at 100% for the balance of the calendar year. However, benefits for expenses incurred for that person for or in connection with Mental Illness, Alcoholism and Drug Dependency while not confined in a hospital will continue to be payable as provided in the Schedule.

MAXIMUM BENEFIT PROVISION. The total amount of Comprehensive Medical Benefits payable for all expenses incurred for an Employee or Dependent in his lifetime will not exceed the Maximum Benefit shown in The Schedule.

However, once a person uses any portion of his Maximum Benefit, on each January 1st the Insurance Company will reinstate the used amount up to $1,000 to be applied to Covered Expenses incurred after the date of reinstatement.

At any time after the benefits charged to an individual's overall maximum reach a total of at least $1,000, the full maximum will be reinstated upon submission to the Insurance Company of satisfactory proof that the individual is in good health.

[Section 7 (NV-Rev. 8-84) 7-1]

For Employees and Dependents

COMPREHENSIVE MEDICAL BENEFITS

(Continued)

MENTAL ILLNESS MAXIMUM. The total amount of Comprehensive Medical Benefits payable for all expenses incurred for an Employee or Dependent in a calendar year for or in connection with mental illness while he is not Confined in a Hospital will not exceed the Mental Illness Maximum shown in The Schedule. The maximum number of visits covered for treatment of mental illness while not confined in a hospital is fifty in one calendar year.

MENTAL ILLNESS BENEFIT. The total amount of Comprehensive Medical Benefits payable for an inpatient hospital patient for mental and nervous disorders will be thirty days per benefit year.

MENTAL ILLNESS PARTIAL HOSPITALIZATION. If partial hospitalization services or a combination of inpatient and partial hospitalization are utilized under the direction of a licensed physician, the total benefit paid for all such services shall not exceed the cost of thirty days of inpatient hospitalization for psychiatric services, including physician fees, which prevail in the community in which the partial hospitalization services are rendered.

SPECIAL CARE FACILITY MAXIMUM. The total amount of Comprehensive Medical Benefits payable for all expenses incurred for an Employee or a Dependent in a calendar year for charges made by a Special Care Facility will not exceed the Special Care Facility Maximum shown in The Schedule.

ALCOHOLISM AND DRUG ABUSE. Benefits will be provided for treatment provided by or under the supervision of or prescribed by a licensed physician or licensed psychologist if such services are provided in a program accredited by the Joint Commission on Accreditation of Hospitals or approved by the state. The total payment for such benefits will not exceed the inpatient and outpatient Drug and Alcohol course of treatment maximums shown in The Schedule.

PRE-EXISTING CONDITION BENEFIT FOR PERSONS INSURED AFTER THE INITIAL GROUP. The Insurance Company will pay up to a maximum of two thousand dollars for covered charges incurred for the treatment of a condition which existed prior to the date insured for these benefits. The deductible shown in The Schedule will not apply to this benefit.

[Section 7 7-2]

For Employees and Dependents

COMPREHENSIVE MEDICAL BENEFITS

(Continued)

COVERED EXPENSES. The term Covered Expenses means the expenses incurred by or on behalf of an Employee or a Dependent for the Charges listed below, if they are incurred after such person becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician and are essential for the necessary care and treatment of an Injury or a Sickness. The following paragraphs describe the Covered Expenses.

(1) charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies, provided that charges for Bed and Board do not exceed the Hospital's semi-private room rate.

(2) charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.

(3) charges made by a Surgeon or Assistant Surgeon for the following professional services:

(a) the immediate pre-operative examination by the doctor performing the procedure.

(b) performance of the procedure.

(c) assistance with the procedure where required by the nature of that procedure or by the patient's condition, provided it is not performed in a hospital having available staff physicians qualified to provide such assistance.

(4) charges made for the following services while being hospital confined: anesthetics and their administration; diagnostic X-ray and laboratory examinations; X-ray, radium and radioactive isotope treatment; chemotherapy; blood transfusions and blood not donated or replaced; oxygen and other gases and their administration.

(5) charges for eligible expenses relating to an accident and incurred within 90 days of that accident and follow-up care. Charges incurred after 90 days will be treated as any other illness to the extent covered by the policy.

[Section 7 7-3]

For Employees and Dependents

COMPREHENSIVE MEDICAL BENEFITS

(Continued)

(6) charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient, except for charges relating to an accident and incurred with 90 days will be treated as any other illness to the extent covered by the policy.

(7) charges made by a Special Care Facility, on its own behalf, for medical care and treatment; except that Covered Expenses will not include that portion of such charges for any one day which is more that the Special Care Facility Daily Limit shown in The Schedule.

(8) charges made by a Physician or a Psychologist for professional services.

(9) charges made by a Nurse, other than a member of the Employee's or Dependent's family, for professional nursing services.

(10) charges made for the following services in a physician's office or on an outpatient basis: X-ray, radium and radioactive isotope treatment; chemotherapy; blood transfusions and blood not donated or replaced; oxygen and other gases and their administration; rental or, at the Insurance Company's option, purchase of durable equipment which is solely used for a medical purpose; physical therapy by a licensed physical therapy by a licensed physical therapist; purchase and fitting or prosthetic appliances; dressings; the first set of contact lenses or eyeglasses made necessary by cataract surgery.

(11) drugs and medicines lawfully dispensed only upon the written prescription of a Physician, excluding vitamins.

[Section 7 7-4]

INSURING PROVISIONS

For Employees and Dependents

COMPREHENSIVE MEDICAL BENEFITS

(Continued)

(12) dentist's charges for surgical removal of an impacted tooth, up to the following maximum charge level:

Impacted tooth, one, excision of - (soft tissue impactions excepted)	Maximum Charges

Partially unerupted from jaw bone -	
Maxilla	$18.00
Mandible	30.00
Completely unerupted from jaw bone	60.00

When two or more impacted teeth are excised during the same operative session, the maximum charges for all such excisions shall be limited to the sum of (i) the largest Maximum Payment otherwise applicable to one of the excisions and (ii) 50% of the maximum payment otherwise applicable to each of the other excisions.

(13) convalescent nursing home charges for confinement after a covered hospital stay of at least three consecutive days. The confinement must start within fifteen days after release from the hospital and be prescribed by a doctor for the condition which caused hospitalization.

(14) charges made by a Home Health Care Agency for the following medical services and supplies provided under the terms of a Home Health Care Plan for the person named in that plan:

(a) part-time or intermittent nursing care by or under the supervision of a Registered Graduate Nurse;

(b) part-time or intermittent services of a Home Health Aide;

(c) physical, occupational or speech therapy;

(d) medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent that such charges would have been considered Covered Expenses had the Employee or

Dependent required confinement in the Hospital as a registered bed patient or confinement in a Skilled Nursing Facility;

[Section 7 7-5]

excluding any charges for:

(a) more than 40 home health care visits during a calendar year; (to determine the benefits payable, each visit by an employee of a Home Health Care Agency will be considered one home health care visit and each 4 hours of Home Health Aide services will be considered one home health care visit.);

(b) care or treatment which is not stated in the Home Health Care Plan;

(c) the services or a person who is a member of the Employee's or Dependent's family or who normally lives in the Employee's or Dependent's home;

(d) a period when the Employee or Dependent is not under the continuing care of a physician.

(15) Charges for two prosthetic devices and reconstructive surgery incident to a mastectomy. Charges for reconstructive surgery which begins more than three years after a mastectomy shall be subject to all the terms, conditions and exclusions in the policy at the time of such surgery.

(16) Services rendered by a Hospice shall be on the same basis as any other health care provider services covered by the policy, provided, the Hospice meets the standards and any licensing requirement of the state of locality in which it operates.

[Section 7 7-6]

INSURING PROVISIONS

For Employees and Dependents

COMPREHENSIVE MEDICAL BENEFITS

(Continued)

EXPENSES NOT COVERED. Covered Expenses will not include, and no payment will be made for, expenses incurred:

(1) for that portion of charges made for any one day for hospital bed and board which exceed the hospital's semi-private room rate.

(2) for that portion of charges made for any one day for or in connection with mental illness, while the Employee or Dependent is not Confined in a Hospital, which is more than the Mental Illness Daily Limit shown in The Schedule.

(3) for or in connection with cosmetic surgery unless (a) the Employee or Dependent receives an Injury, while insured for these benefits, which results in bodily damage requiring the surgery; or (b) it qualifies as reconstructive surgery performed on the Employee or Dependent following surgery are medically necessary; or (c) it is required to provide; or restore a normal bodily function.

(4) for eyeglasses, hearing aids or examinations for prescription or fitting thereof.

(5) for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for or in connection with dental work due to an Injury to sound natural teeth sustained while the Employee or Dependent is insured for these benefits; or (b) charges made by a Hospital for Bed

and Board or Necessary Services and Supplies; or (c) charges made by a Physician for a Surgical Procedure.

(6) for which benefits are not payable according to the "General Limitations" section.

(7) for or in connection with an Injury or sickness which is more than the Pre-existing Condition benefit shown in The Schedule unless those expenses are incurred after the earlier of: (a) a 90-day period, which ends while the Employee or Dependent is insured for these benefits, during which he receives no treatment, incurs no expenses and receives no diagnosis from a Physician in connection with that Injury or Sickness; or (b) a one-year period during which such Employee or Dependent is continuously insured for these benefits.

INSURING PROVISIONS

For Employees and Dependents

COMPREHENSIVE MEDICAL BENEFITS

PRE-EXISTING CONDITION. A Pre-existing Condition is an Injury or a Sickness for which an Employee or a Dependent receives treatment, incurs expenses or receives advice from a Physician during the 90 days prior to the date such Employee or Dependent becomes insured for these benefits. The term Pre-existing Condition will also include any condition which is related to any such Injury or Sickness.

COMMON ACCIDENT. If an Employee and one or more of his insured Dependents or if two or more of his insured Dependents are injured in the same accident and incur Covered Expenses for those injuries in the calendar year in which the accident occurs, not more than one Comprehensive Medical Deductible will be deducted from the total

Covered Expenses incurred for those persons during the rest of that calendar year.

MULTIPLE BIRTH. Not more than one Comprehensive Medical Deductible will be deducted from the total Covered Expenses incurred in a calendar year for two or more Dependents born in a multiple birth if those Covered Expenses are incurred in the same calendar year in which they are born and are due to:

(1) premature birth;

(2) abnormal congenital condition; or

(3) Injury which is received or Sickness which starts not more than 30 days after their birth.

INSURING PROVISIONS

For Employees and Dependents

COMPREHENSIVE MEDICAL BENEFITS

SECOND OPINION SURGICAL BENEFITS. If, as a result of an Injury or a Sickness, an Employee or a Dependent, while insured for these benefits and prior to the performance of an Elective Surgical Procedure recommended by a surgeon, asks for an opinion from another Physician who is qualified to diagnose and treat that Injury or Sickness, the Insurance Company will pay 100% of the Covered Expenses incurred for the fee charges for that opinion. If the Employee or Dependent incurs Covered Expenses for additional diagnostic laboratory or X-ray examinations not previously requested and asked for by the Physician who gives that opinion, the Insurance Company will pay 100% of the Covered Expenses so incurred.

THIRD OPINION SURGICAL BENEFITS. If the first and second opinion for elective surgery conflict and the Employ-

ee or Dependent asks for a third opinion from another Physician who is qualified to diagnose and treat that Injury or Sickness, the Insurance Company will pay 100% of the Covered Expense incurred for the fee charged for the third opinion. If the Employee or Dependent incurs Covered Expenses for additional diagnostic laboratory or X-ray examinations not previously requested and asked for by the Physician who gives the third opinion, the Insurance Company will pay 100% of the Covered Expenses.

Payment will be made whether or not the Surgical Procedure is performed.

Payment will be subject to all terms of the policy except as otherwise provided in this section.

The benefits described above are not subject to the Comprehensive Medical Deductible.

LIMITATIONS. No payment will be made for expenses incurred in connection with:

(1) cosmetic or dental Surgical Procedures not covered under the policy;

(2) minor Surgical Procedures that are routinely performed in a Physician's office, such as incision and drainage for abscess or excision of benign lesions;

(3) an opinion obtained more than 6 months after a surgeon has recommended the Elective Surgical Procedure.

Other Limitations are shown in the "General Limitations" section.

No payment will be made under any other section of the policy for expenses incurred to the extent that benefits are payable for those expenses under this section.

INSURING PROVISIONS

For Employees and Dependents

COMPREHENSIVE MEDICAL BENEFITS

(Continued)

ELECTIVE SURGICAL PROCEDURE. The term Elective Surgical Procedure means a Surgical Procedure which is not considered emergency in nature and which may be avoided without undue risk to the individual.

OUTPATIENT PRE-ADMISSION TESTING BENEFITS. If an Employee or Dependent, while insured for these benefits immediately prior to being admitted as an inpatient and prior to the performance of a surgical procedure recommended by a Surgeon, incurs Covered Expenses for diagnostic laboratory or X-ray examinations asked for by the Surgeon, and these examinations are performed on an outpatient basis before being admitted to the Hospital, the Insurance Company will pay 100% of the Covered Expenses so incurred.

Payment will be made whether or not the surgical procedure is performed. Payment will be subject to all terms of the policy except as otherwise provided in this section.

The benefits described above are not subject to the Comprehensive Medical Deductible.

LIMITATIONS. No payment will be made under any other section of the policy for expenses incurred to the extent that benefits are payable for those expenses under this section.

INSURING PROVISIONS

SPECIAL PROVISIONS FOR NEWBORN DEPENDENT MEDICAL BENEFITS

EFFECTIVE DATE OF INSURANCE. Any Dependent child born while the Employee is insured for Dependent Insurance will be insured from the moment of birth. A Dependent child born while the Employee is insured for himself but not for his Dependents, will become insured from the moment of birth if the Employee elects Dependent Insurance no later than 31 days after the child's birth.

BENEFITS PAYABLE. If a Newborn Dependent, while insured, incurs expenses as a result of an Injury or Sickness, the Insurance Company will pay for those expenses to the same extent as those payable for any other insured Dependent. Benefits will also be payable for transportation charges to and from the nearest available facility staffed and equipped to treat the Newborn Dependent's condition. The transportation must be certified by a Physician as medically necessary. The maximum amount payable for transportation charges for a Newborn Dependent will be no less than $1,000.

In addition to the above, expenses incurred for routine care of the Newborn Dependent prior to the date of discharge from the Hospital nursery will be deemed to result from a Sickness.

SICKNESS. Sickness also includes medically diagnosed congenital defects, birth abnormalities or Premature Birth.

PREMATURE BIRTH. Premature Birth means a child born too early as determined by a Physician.

LIMITATIONS. No payment will be made:

(1) for expenses incurred for transportation charges made in connection with routine care of a Newborn Dependent;

(2) under any other section for expenses incurred to the extent that benefits are payable for those expenses under this section.

Other Limitations are shown in the "General Limitations" section.

[Section 7 7-10]

INSURING PROVISIONS

CHANGE OF INSURER. When this plan replaces a prior medical policy of the Employer, the following applies to Covered Members who:

(1) Were insured by the prior plan on the day before this plan was issued and

(2) Became a member on the first day under this plan.

Coverage is effective whether or not the Employee is actively working or the Dependent is confined to a hospital on that date.

The Pre-Existing conditions limitations will be modified as follows:

(1) If the Pre-Existing Conditions Limitation is satisfied, expenses will be covered under this plan; or

(2) If the Pre-Existing Conditions Limitation is not satisfied, benefits may still be payable, subject to the following:

(a) if the pre-existing limitation of the prior plan was satisfied when that plan terminated, benefits will be provided for the pre-existing condition. The amount of Covered Expense will be the lesser of the prior plan's benefits or the benefits under this policy; or

(b) if the pre-existing limitations of the prior plan had not been satisfied when that plan terminated,

Members will be permitted to satisfy that limitation while covered under this plan. However, any benefits payable due to a pre-existing condition prior to satisfying that Pre-Existing Conditions Limitation under this plan, will be the lesser of the prior plan's benefits or the benefits under this plan.

If the Employee is totally diabled, or any Dependent is hospital confined on the first day of the plan subject to the Pre-Existing Conditions limitations:

(1) Coverage for the condition causing the total disability or hospital confinement will begin after coverage under the prior plan ends;

(2) Coverage for all other conditions will begin on the effective date of this plan; and

(3) Coverage will continue for all conditions for the period of the prior plan's extended benefits, or 12 months after disability begin, whichever comes first.

[Section 7 (NV-Add 8/84) 7-11]

INSURING PROVISIONS

(Continued)

CHANGE OF INSURER DEDUCTIBLE CREDIT. The amount of the Major Medical Deductible may be reduced if the Employee became insured by this policy on its effective date, and; had been insured by the prior plan of group medical insurance on the day before this policy takes effect.

If these two requirements are met, the Insurance Company will reduce the deductible by any amount of covered expenses incurred under the prior plan which were applied to that plan's deductible.

[Section 7 (NV-Add 8/84) 7-12]

GENERAL LIMITATIONS

No payment will be made for expenses incurred:

(1) for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;

(2) for or in connection with a Sickness which is covered under any workers' compensation or similar law;

(3) for charges made by a Hospital owned or run by the United States Government unless the Employee or Dependent is legally required to pay for such charges;

(4) to the extent that payment is unlawful where the Employee or Dependent resides when the expenses are incurred;

(5) for charges which the Employee or Dependent is not legally required to pay;

(6) for charges which would not have been made if the Employee or Dependent had no insurance;

(7) to the extent that they are more than Reasonable and Customary charges;

(8) for charges for unnecessary care, treatment or surgery;

(9) for or in connection with custodial care, education or training;

(10) to the extent that the Employee or Dependent is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;

(11) for experimental drugs or substances not approved by the Food and Drug Administration, or for drugs labeled: "Caution - limited by Federal law to investigational use," except that in the case that such drugs or substances become approved by the Food and Drug Administration, they will be covered from that time on;

(12) for or in connection with experimental procedures or treatment methods not approved by the American Medical Association or the appropriate medical specialty society, except that in the case that such procedures or methods become approved by the American Medical Association or the appropriate medical specialty society, they will be covered from that time on.

GENERAL LIMITATIONS

(Continued)

No payment will be made for expenses incurred by an Employee or a Dependent:

(1) To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with:

(a) a "no-fault" insurance law; or

(b) an uninsured motorist insurance law.

The Insurance Company will take into account any adjustment option chosen under such part by the Employee or Dependent.

(2) For or in connection with an elective abortion unless:

(a) the Physician certifies in writing that the pregnancy would endanger the life of the mother; or

(b) the expenses are incurred to treat medical complications due to the abortion.

The Medical Expense Insurance for an Employee or a Dependent who is age 65 or older and eligible for Medicare will be modified as follows:

(1) If expenses are incurred for which benefits are payable under both this plan and Part A of Medicare, benefits will be payable under this plan only for those expenses so incurred which exceed the amount payable under Part A of Medicare.

(2) The amount payable under this plan for expenses in curred for which benefits are payable under both this plan and Part B of Medicare will be reduced by the amount payable for those expenses under Part B of Medicare.

(3) The deductible will apply only to Covered Expenses incurred for prescription drugs and charges made by a Nurse.

For an Employee or a Dependent who is less than age 65 and eligible for Medicare, the amount payable under this plan will be reduced so that the total amount payable by the Insurance Company and Medicare will be no more than 100% of the expenses incurred.

The Insurance Company will assume the amount payable under Part B of Medicare for any person who is eligible to enroll in that Part, but did not, to be the amount he would receive if he had enrolled.

A person is considered eligible for Medicare on the earliest date coverage under Medicare could become effective for him.

Where applicable due to the Tax Equity and Fiscal Responsibility Act of 1982 actively working employees ages 65 to 69 may elect one of the following options:

(1) Medical benefits under this plan will be paid first (primary). The the benefits of Medicare will be paid second (secondary). The option elected by the Employee will also apply to the employee's spouse age 65 to 69; or

(2) Medicare benefits only. The employee (and his dependents, if any) will not have coverage under this plan.

The employer must provide each actively working employee with the opportunity to elect one of these options at least one month prior to the month in which the employee becomes age 65. All new employees aged 65 to 69 must be permitted to elect an option when hired.

If medical coverage under this plan is elected (Option 1), its issue will be subject to the same requirements as for an employee or dependent under age 65.

A spouse aged 65 to 69 of an actively working employee who is under age 65, or age 70 or older, will receive benefits payable by Medicare before any benefits payable under this plan. The benefits of the plan will be reduced for a Medicare benefit the person is entitled to receive (including Part B), whether or not Medicare coverage has been applied for.

[Section 9 (NV-Rev. 8/84) 9-1]

MEDICARE ELIGIBLES

(Continued)

An actively working employee aged 70 and older, or a spouse aged 70 and older, or retired employees and their spouses, will receive benefits payable under Medicare before any medical benefits payable under this plan. The benefits of this plan will be reduced for any Medicare benefit the person is entitled to receive (including Part B), whether or not Medicare coverage has been applied for.

An employee's dependents (other than a spouse) who are eligible for Medicare will receive benefits payable under Medicare before any medical benefits payable under this plan. The benefits of this plan will be reduced for any

Medicare benefit the person is entitled to receive (including Part B), whether or not Medicare coverage has been applied for.

[Section 9 (NV-Rev. 8/84) 9-2]

CO-ORDINATION OF BENEFITS

If a person covered under this policy (called "this Plan") is also covered under one or more other Plans, the benefits payable for him from this Plan will be co-ordinated with the benefits payable for him from all other Plans.

Co-ordination of Benefits will be used to determine the benefits payable for a person for any Claim Determination Period if, for the Allowable Expenses incurred in that Period, the sum of (a) and (b) below would exceed those Allowable Expenses:

(a) the benefits that would be payable from this Plan without co-ordination; and

(b) the benefits that would be payable from all other Plan without Co-ordination of Benefits provisions in those Plan.

The benefits that would be payable from this Plan for Allowable Expenses incurred in any Claim Determination Period without Co-ordination of Benefits will be reduced to the extent required so that the sum of:

(a) those reduced benefits; and

(b) all the benefits payable for those Allowable Expenses from all other Plans

will not exceed the total of those Allowable Expenses. Benefits payable from all other Plans include the benefits that would have been payable had proper claim been made for them.

[Section 10 10-1]

CO-ORDINATION OF BENEFITS

(Continued)

However, the benefits of another Plan will be ignored when the benefits of this Plan are determined if:

(a) the Benefit Determination Rules would require this Plan to determine its benefits before that Plan; and

(b) the other Plan has a provision that co-ordinates its benefits with those of this Plan and would, based on its rules, determine its benefits after this Plan.

When Co-ordination of Benefits reduces the total amount otherwise payable in a Claim Determination Period for a person covered under this Plan, each benefit that would be payable in the absence of Co-ordination of Benefits will be reduced in proportion. The reduced amount will be charged against any applicable benefit limit of this Plan.

The Insurance Company reserves the right to release to or obtain from any other insurance company or other organization or person any information which, in its opinion, it needs for the purpose of Co-ordination of Benefits.

When payments which should have been made under this Plan based on the terms of this section have been made under any other Plans, the Insurance Company will have the right to pay to any organizations making these payments the amount it determines to be warranted. Amounts paid in this manner will be considered to be benefits paid under this Plan. The Insurance Company will be released from all liability under this Plan to the extent of these payments.

When an overpayment has been made by the Insurance Company, at any time, it will have the right to recover that payment, to the extent of the excess, from the person to whom it was made or any other insurance company or organization, as it may determine.

CO-ORDINATION OF BENEFITS

(Continued)

BENEFIT DETERMINATIONS RULES. The rules below establish the order in which benefits will be determined:

(1) The benefits of a Plan which covers the person for whom claim is made other than as a dependent will be determined before a Plan which covers that person as a dependent.

(2) The benefits of a Plan which covers the person for whom claim is made as a dependent of a male will be determined before a Plan which covers that person as a dependent of a female; except that, in the case of a dependent child of divorced or separated parents, the following rules will apply.

If there is a court decree which establishes financial responsibility for medical, dental or other health care of the child, the benefits of the Plan which covers the child as a dependent of the parent so responsible will be determined before any other plan; otherwise:

(a) The benefits of a Plan which covered the child as a dependent of the parent of the parent with custody will be determined before a Plan which covers the child as dependent of a stepparent or a parent without custody.

(b) The benefits of a Plan which covers the child as a dependent of a stepparent will be determined before a plan which covers the child as a dependent of the parent without custody.

(3) When the above rules do not establish the order, the benefits of a Plan which has covered the person for

whom claim is made for the longer period of time will be determined before a Plan which has covered the person for the shorter period of time; provided that:

(a) the benefits of a Plan covering the person on whose expenses claim is based as laid-off or retired employee or as the dependent of such person shall be determined after the benefits of any other Plan covering such person as an employee other than as a laid-off or retired employee or a dependent of such person; and

(b) if either Plan does not have a provision regarding laid-off or retired employees, and, as a result, each Plan determines its benefits after the other, then the provisions of (a) above shall not apply.

CO-ORDINATION OF BENEFITS

(Continued)

DEFINITIONS

PLAN. Plan means any:

(1) group insurance coverage;

(2) service plan contracts, group of individual practice or other prepayment plans; or

(3) coverage under any labor-management trusteed plans, union welfare plans, employer organizations plans, or employee benefit organization plans;

which provides medical or dental benefits or services. It does not include coverage under individual or franchise policies or contracts.

Each Plan or part of a Plan which has the right to co-ordinate benefits will be considered a separate Plan.

ALLOWABLE EXPENSE. Allowable Expense means any necessary, reasonable and customary item of expense at least a part of which is covered by any one of the Plans that covers the person for whom claim is made.

When the benefits from a Plan are in the form of services, not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid.

CLAIM DETERMINATION PERIOD. Claim Determination Period means a calendar year or that part of a calendar year in which the person has been covered under this Plan.

PAYMENT OF CLAIMS

TO WHOM PAYABLE: All medical benefits are payable to the Employee. However, with the consent of the Insurance Company and the Policyholder, an insured may direct that all or any part of the medical benefits may be paid directly to the person or institution on whose charge claim is based.

If any person to whom benefits are payable is a minor or, in the opinion of the Insurance Company, is not able to give valid receipt for any payment due him, such payment will be made to his legal guardian. However, if no request for payment has been made by his legal guardian, the Insurance Company may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

The Insurance Company will pay benefits for covered services after the insured person has satisfied the deductible and other co-insurance amounts he is obligated to pay. Obligated to pay means the amount of charges the insured employee or his dependents must pay. It does not include any charges which are discounted, rebated or waived. The amount of any discount, rebate, waived charges or charges the insured

employee or his insured dependents are not obligated to pay shall not be considered covered charges under this contract. The Insurance Company shall have the right to recover from a provider of services or insured employee any excess benefit payments made as a result of a discount, rebate, waived charges or charges the insured employee or his insured dependents are not obligated to pay.

If an Employee dies while medical benefits remain unpaid, the Insurance Company may choose to pay benefits up to $3,000 to a person or persons related to the Employee by blood or marriage who appears to be entitled to the benefits; or the executors of administrators of the Employee's estate. The Insurance Company will be discharged to the extent of any such payment made in good faith.

TIME OF PAYMENT OF CLAIMS. Medical benefits will be paid by the Insurance Company when it receives proper written proof of loss.

SUBROGATION. In the event of any payment for benefits provided to an insured under this policy, the Insurance Company, to the extent of such payment, shall be subrogated to all rights of recovery such insured has against any person or organization. The insured shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Insurance Company. Where state law eliminates the insureds right to recover amounts received from collateral sources, this provision shall not apply and the Insurance Company shall have no right to subrogation or indemnification against any person or organization and shall not require that the insured execute or deliver any instrument or paper in order to protect or secure subrogation or recovery rights to the Insurance Company.

In the event the insured person initiates action and makes recovery from any person or organization, the amount due

the Insurance Company will be subject to a pro-rata share of attorney fees.

[Section 11 (NV-Rev. 8/84) 11-1]

TERMINATION OF INSURANCE

For Employees

The insurance on an Employee will cease on the earliest date below:

(1) the date the Employee ceases to be in a Class of Eligible Employees or ceases to qualify as an Employee;

(2) the last day for which the Employer has made any required contribution for the insurance;

(3) the date the policy is cancelled;

(4) the date the Employee's Active Service ends, except as set forth below.

TEMPORARY LAYOFF OR LEAVE OF ABSENCE. If an Employee's Active Service ends due to temporary layoff or leave of absence, the insurance will be continued until the Policyholder stops paying premium for the Employee or otherwise cancels the insurance. However, the insurance will not continue for more than 60 days past the date the Employee's Active Service ends.

INJURY OR SICKNESS. If an Employee's Active Service ends due to an Injury or a Sickness, the insurance will be continued for up to 12 months during disability leave or absence while the Employee remains totally and continuously disabled as a result of the Injury or Sickness. However, the insurance will not continue past the date the Policyholder stops paying premium for the Employee or otherwise cancels the insurance.

RETIREMENT. If an Employee's Active Service ends because he retires, the insurance will be continued until the

date on which the Policyholder stops paying premium for the Employee or otherwise cancels the insurance.

Any continuation of insurance must be based on a plan which precludes individual selection.

[Section 12 (NV-Rev. 8/84) 12-1

TERMINATION OF INSURANCE

(Continued)

For Dependents

An Employee's insurance for all of his Dependents will cease on the earliest date below:

(1) the date of the Employee's insurance for himself ceases, except in the case of death;

(2) the date the Employee ceases to be in a class of Employees eligible for Dependent Insurance;

(3) the last day for which the Employee has made any required contribution for Dependent Insurance;

(4) the date Dependent Insurance is cancelled.

An Employee's insurance for any one of his Dependents will cease on the date the Dependent no longer qualifies as a Dependent.

DEPENDENT MEDICAL INSURANCE AFTER EMPLOYEE'S DEATH. If an Employee is insured for Medical Expense Insurance when he dies, any of his Dependents who are then insured for Medical Expense Insurance, except a Dependent who is eligible for Medicare, will remain so insured without further payment of premiums for them. However, the insurance on any of those Dependents will cease on the earliest date below;

(1) the last day of the twelfth month after the Employee's death;

(2) the date of remarriage of a surviving spouse, if any;

(3) the date that Dependent qualifies for Medicare;

(4) the date that Dependent ceases to qualify as a Dependent for a reason other than last of primary support by the Employee.

The Dependent benefits payable after the Employee dies will be those in effect on his last day of Active Service.

[Section 12

12-2]

MEDICAL BENEFITS EXTENSION

If this policy terminates for the entire group, any expense incurred within 12 months after a persons's Comprehensive Medical Benefits cease will be deemed to be incurred while he is insured if such expense is for an Injury or a Sickness which causes him to be Totally Disabled from the day his insurance ceases until that expense is incurred.

The terms of this Medical Benefits Extension will not apply to (a) a child born as a result of a pregnancy which exists when a person's benefits cease; or (b) any person when he becomes insured under another group policy for medical benefits.

TOTALLY DISABLES. An Employee will be considered Totally Disabled if, because of an Injury or a Sickness:

(1) he is unable to perform the basic duties of his occupation; and

(2) he is not performing any other work or engaging in any other occupation for wage or profit.

A Dependent will be considered Totally Disabled if, because of an Injury or a Sickness:

(1) he is unable to engage in the normal activities of a person of the same age, sex and ability; or

(2) in the case of a Dependent who normally works for wage or profit, he is not performing such work.

[Section 13 13-1]

MEDICAL CONVERSION PRIVILEGE

For Employees and Dependents

When an Employee's or a Dependent's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy or certificate of medical care benefits (called the Converted Policy) issued by the Insurance Company. A Converted Policy will be issued by the Insurance Company only to a person who is Entitled to Convert, and only if he applies in writing and pays the first premium for the Converted Policy to the Insurance Company within 31 days after the date his insurance ceases. Evidence of good health is not needed. The Insurance Company will provide all necessary information to a person who is Entitled to Convert, so that application may be made.

EMPLOYEES ENTITLED TO CONVERT. An Employee is entitled to Convert Medical Expense Insurance for himself and all of his Dependents who were insured when his insurance ceased, provided such persons have been continuously insured for at least 3 months under this policy and any group policy providing similar benefits which it replaced, except a Dependent who is eligible for Medicare or would be Overinsured, but only if:

(1) The Employee's insurance ceased because he was no longer in Active Service or no longer eligible for Medical Expense Insurance.

(2) The Employee does not replace this group plan within 31 days by another group plan.

(3) The Employee is not eligible for Medicare.

(4) The Employee would not be Overinsured.

A retired Employee may apply for a Converted Policy within 31 days after his retirement date in place of any continuation of his insurance that may be available under this plan when he retires, if he is otherwise Entitled to Convert.

DEPENDENTS ENTITLED TO CONVERT. The following Dependents are also Entitled to Convert:

(1) a child whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of the Employee's death;

(2) a spouse whose insurance under this plan ceases due to divorce, annulment of marriage or the Employee's death;

(3) the Dependents of an Employee, if the Employee is not Entitled to Convert solely because he is eligible for Medicare;

but only if that Dependent: (a) was insured when the Employee's insurance ceased; (b) is not eligible for Medicare; and (c) would not be Overinsured.

[Section 14 14-1]

MEDICAL CONVERSION PRIVILEGE

(Continued)

For Employees and Dependents

OVERINSURED. A person will be considered Overinsured if either (1) or (2) occurs:

(1) His insurance under this plan is replaced by similar group coverage within 31 days.

(2) The benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on the Insurance Company's underwriting standards for individual policies. Similar Benefits are: (a) those for which the person is covered by another hospital, surgical or medical expense insurance policy or a hospital or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; or (b) those for which the person is eligible, whether or not covered, under any plan or group coverage on an insured or uninsured basis; or (c) those available for the person by or through any state, provincial or federal law.

CONVERTED POLICY. An Employee entitled to a Converted Policy for himself and dependents will be entitled to a choice of 3 policies offering benefits on a expense incurred basis. The choice of policies offered will include a policy with the benefit level provided by this policy. The Insurance Company may provide a Medicare Supplement policy for a person eligible for Medicare.

The Converted Policy will be issued to the Employee if he is Entitled to Convert, insuring him and those Dependents for whom he may convert. If the Employee is not Entitled to Convert and his spouse and children are, it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: (a) class of risk and age; and (b) benefits.

MEDICAL CONVERSION PRIVILEGE

(Continued)

For Employees and Dependents

This Converted Policy may not exclude any pre-existing condition not excluded by this plan. During the first 12 months the Converted Policy is in effect, the amount payable under it will be reduced so that the total amount payable will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan.

The Insurance Company or the Policyholder will give the Employee, on request, further details of the Converted Policy.

PREMIUMS

PREMIUM PAYMENT. The first premium will be due on the Effective Date. After that, premium will be due monthly unless the Policyholder and the Insurance Company agree on some other method of premium payment. The Policyholder and the Insurance Company may agree to change the method of premium payment from time to time. Premiums are payable at the Home Office of the Insurance Company or to an authorized agent of the Insurance Company.

PREMIUM DUE DATE. After the Effective Date, the Premium Due Date will be the day of the month with the same number as the Anniversary Date of the last day of a month in which there is no day with the same number as the Anniversary Date.

MONTHLY STATEMENT DATE. The Monthly Statement Date will be the same as the Premium Due Date.

MONTHLY PREMIUM STATEMENT. A Monthly Premium Statement will be prepared as of the Premium Due Date. This Monthly Premium Statement will show the premium due. This Monthly Statement will reflect any pro rata premium charges and credits due to changes in the number of insured persons and changes in insurance amounts that took place in the preceding month.

SIMPLIFIED ACCOUNTING. To simplify the accounting process, premium adjustments will be made on the Monthly Statement Date that is the same as or next follows the date that (1), (2) or (3) below takes place:

(1) A person becomes insured.

(2) The amount of insurance on a person changes, but not due to a revision of The Schedule.

(3) A person ceases to be insured.

PREMIUMS

(Continued)

MONTHLY PREMIUM RATE. The monthly premium rate per Employee is as follows:

For Family Insurance
$113.00

CALCULATION OF PREMIUMS. The monthly premium will be calculated as follows:

(1) Multiply the number of Employees insured on the Premium Due Date in each rate class shown in the

"Monthly Premium Rate" section by the premium rate in effect on that date for that class.

(2) Add the results.

If the Policyholder and the Insurance Company agree to a change in the method of premium payment or to a change in the Anniversary Date, a pro rata adjustment will be made in the premium due.

CHANGES IN PREMIUM RATES. Any premium rate may be changed by the Insurance Company from time to time with at least 31 days advance written notice. No change in rates will be made until 12 months after the Effective Date. An increase in rates will not be made more often than once in a 12 month period.

However, the Insurance Company may change rates immediately if, in its opinion, its liability is altered by any change in state or federal law or by a revision in the insurance under the policy. Any such change in rates will take effect on the effective date of the change in law or change in the insurance.

If an increase in rates takes place on a date that is not a Premium Due Date, a pro rata premium will be due on the date of the increase. The pro rata premium will apply for the increase from the date of the increase to the next Premium Due Date. If a decrease in rates takes place on a data that is not a Premium Due Date, a pro rata credit will be granted. The pro rata credit will apply for the decrease from the date of the decrease to the next Premium Due Date.

As of any Anniversary Date after the policy has been in force for 12 months, the Insurance Company may grant a credit in such amount as it may determine, based on experience. The experience under this policy may be combined with the experience under other group insurance policies issued by the Insurance Company to the Policyholder. If the

Insurance Company grants a credit, the excess, if any, of the policyholder fund paid for the coverage including the cost of Administration, shall be applied for the benefit of insured employees or members.

[Section 15 (NV-Rev. 8-84) 15-2]

CANCELLATION OF POLICY

The Policyholder may cancel the policy as of any Premium Due Date by giving written notice to the Insurance Company before that date.

The Insurance Company may cancel the policy as of any Premium Due Date if the number of insured Employees is less than 25 or less than 75% of those eligible. Dependent Insurance may be cancelled as of any Premium Due Date if the number of Employees insured for their Dependents is less than 75% of those eligible.

If a premium is not paid when due, the policy will automatically be cancelled as of the Premium Due Date, except as set forth below.

GRACE PERIOD. If, before a Premium Due Date, the Policyholder has not given written notice to the Insurance Company that the policy is to be cancelled, a Grace Period of 31 days will be granted for the payment of each premium after the initial premium. The policy will stay in effect during that time. If any premium is not paid by the end of the Grace Period; except that, if the Policyholder has given written notice in advance of an earlier date of cancellation, the policy will be cancelled as of the earlier date. The Policyholder will be liable to the Insurance Company for any unpaid premium for the time the policy was in force.

[Section 16 (NV-Rev. 8/84) 16-1]

PROVISIONS

EXECUTION OF POLICY. The policy is executed at the Home Office of the Insurance Company. The Post Office Address of the Insurance Company is 3201 South Maryland Parkway, Suite 118, Las Vegas, NV 89109.

CONSIDERATION. The policy is issued to the Policyholder in consideration of the application and payment of premiums.

INSURANCE DATA. The Policyholder will give the Insurance Company all of the data that it needs to calculate the premium and all other date that it may reasonably require. Failure of the Policyholder to give this data will not void or continue an Employee's insurance. The Insurance Company has the right to examine the Policyholder's records relative to these benefits at any reasonable time while the policy is in effect. It also has the right until all rights and obligations under the policy are finally determined.

INCORRECT PREMIUM PAYMENT. Premiums paid in error for a person who is not eligible to be insured, or for a person after his insurance has ceased, will be refunded without interest when requested by the Policyholder. These premiums will not be refunded, however, for more than a 6-month period, nor for any period before the last Anniversary Date.

MALE PRONOUN. The male pronoun as used herein will be deemed to include the female.

[Section 17 17-1]

PROVISIONS

(Continued)

ENTIRE CONTRACT. The entire contract will be made up of the policy, the application of the Policyholder, a copy of

which is attached to the policy and the applications, if any, of the Employees.

POLICY CHANGES. Changes may be made in the policy only by amendment signed by the Policyholder and by the Insurance Company acting through its President, Vice President, Secretary or Assistant Secretary. No agent may change or waive any terms of the policy.

STATEMENTS NOT WARRANTIES. All statements made by the Policyholder or by an insured Employee will, in the absence of fraud, be deemed representations and not warranties. No statement made by the Policyholder or by the Employee to obtain insurance will be used to avoid or reduce the insurance unless it is made in writing and is signed by the Policyholder or the Employee and a copy is sent to the Policyholder, the Employee or his Beneficiary.

NOTICE OF CLAIM. Written notice of claim must be given to the Insurance Company within 30 days after the occurrence or start of the loss on which claim is based.

If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonable possible.

CLAIM FORMS. When the Insurance Company receives the notice of claim, it will give to the claimant, or to the Policyholder for claimant, the claim forms it used for filing proof of loss. If the claimant does not get these claim forms within 15 days after the Insurance Company receives notice of claim, he will be considered to have met the proof or loss requirements if he submits written proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

PROOF OF LOSS Written proof of loss must be given to the Insurance Company within 90 days after the date of the

loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated nor reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

PHYSICIAN EXAMINATION. The Insurance Company, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

[Section 17 17-2]

PROVISIONS

(Continued)

LEGAL ACTIONS. No action at law or in equity will be brought to recover on the policy until at least 60 days after written proof of loss has been filed with the Insurance Company. No action may be brought after expiration of the applicable statute of limitations from the time written proof of loss is required to be given.

TIME LIMITATIONS. If any time limit set forth in the policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity is less than that permitted by the law of the state in which the Employee lives when the policy is issued, then the time limit provided in the policy is extended to agree with the minimum permitted by the law of that state.

PHYSICIAN/PATIENT RELATIONSHIP. The Employee will have the right to choose any physician who is practicing legally. The Insurance Company will in no way disturb the physician/patient relationship.

CERTIFICATES. The Insurance Company will issue to the Policyholder for delivery to each insured Employee an individual certificate. The Policyholder will be responsible for distributing the certificates to its Employees. The certificate

will show the benefits provided under the policy. It will set forth any changes in benefits due to age and to whom benefits will be paid. Nothing in the certificate will change or void the terms of the policy.

[Section 17 17-3]

MEDICAL QUALITY COST MANAGEMENT RIDER

PRE-ADMISSION REVIEW

A physician must obtain prior verification from us that any non-emergency admission of an insured person to a hospital for surgical or medical care is medically necessary as defined by the Group Policy. If we determine that the admission is not medically necessary, but the insured person elects to receive the prescribed care, it will not be covered under the Group Policy.

If the physician does not contact us before the insured person is admitted, we will review the admission on the first working day following the admission. If we determine that the admission is not medically necessary, we will notify the insured person in writing that coverage will end in 24 hours. If the insured person chooses to remain in the hospital beyond that time, any expenses the insured person incurs will be his or her responsibility.

CONTINUED STAY REVIEW

We will review a stay after an insured person is admitted to the hospital. If continued stay in the hospital is determined not to be medically necessary, the insured person will be notified in writing that coverage will end in 24 hours. If the insured person chooses to remain in the hospital beyond that time, the insured person will have to pay any remaining expenses that he or she incurs.

SURGICAL NECESSITY

If a physician recommends that an insured person have elective, non-emergency surgery, the physician must obtain prior verification from us that the procedure is medically necessary. If we determine that the surgery is not medically necessary, or that it can be safely done on an outpatient basis, we will notify the insured person in writing. If the insured person elects to undergo a procedure that has not been verified as medically necessary, he or she will be responsible for any expenses incurred for or in connection with the surgery.

/s/ Alice F. Newton
Secretary

[HCP1-R5 85-7/PRE]

HUMANA HEALTH INSURANCE COMPANY OF NEVADA, INC.

ENDORSEMENT

This Endorsement is made a part of Group Policy 78274.

ACCIDENT BENEFIT. If an Employee or Dependent, as a result of Injury, incurs Covered Expenses in a Participating Hospital for treatment in a hospital emergency room within 72 hours of the onset of that injury, the Insurance Company will pay 100% of the first $500 of those Covered Expenses.

If an Employee or Dependent is admitted to a Non-Participating Hospital on an emergency basis, caused by an injury which is life threatening in nature, the benefits will be paid on the same basis as a Participating Hospital.

The benefits described above are not subject to a Deductible.

No payment will be made under any other section of the policy for expenses incurred to the extent that benefits are payable for those expenses under this section.

_____
Secretary

[HCP-84-HMM-1.4]

HUMANA HEALTH INSURANCE COMPANY
OF NEVADA, INC.

GROUP MEDICAL EXPENSE INSURANCE POLICY

PREMIUM COST AGREEMENT

This Agreement is attached to and becomes a part of the Group Medical Expense Insurance Policy issued to Sahara & Hacienda Hotels on Policy 78274.

This Rider is issued for a term of four (4) years beginning on the effective date of this Rider.

The first contract year is the year beginning on the effective date. The second, third and fourth contract years begins on the first, second and third anniversaries of the effective date, respectively.

Monthly Premium Rates

Plan Year	*Family*
1/01/85 - 12/31/85	$113.00

Humana Health Insurance Company of Nevada, Inc. guarantees the above premium structure from January 1, 1985 to January 1, 1986. It is further guaranteed that this premium will not increase by more than the Consumer Price Index in each of the following three years after the first year, provided that 75% of hospital services are obtained at Participating Hospitals. If less than 75% of hospital services are obtained

in Participating Hospitals in the first contract year, the premium for the second contract year will not increase by more than the Consumer Price Index percentage plus 5%. However, the total increase for the second contract year is guaranteed not to exceed 10%. If less than 75% of hospital services are obtained in Participating Hospitals in any contract year after the second, the premium for the following contract year will not increase by more than the Consumer Price Index percentage plus 5%.

The Consumer Price Index for all Urban Consumers (CPI-U) is the measure of the average change in prices over time in a fixed market basket of goods and services as published by the United States Department of Labor, Bureau of Labor Statistics for the United States as a whole.

HUMANA HEALTH INSURANCE COMPANY OF NEVADA, INC.	SAHARA & HACIENDA HOTELS
BY: /s/ Larry Cash Larry Cash Vice President	BY: /s/ Herman M. Peacock
DATE: 2-6-85	DATE: 2-26-85

[HCP-84-NV-1.1 (NV-Rev. 8-84)]

J. RANDALL JONES, ESQ.
JONES, JONES, CLOSE
& BROWN, CHARTERED
700 Valley Bank Plaza
300 So. Fourth Street
Las Vegas, NV 89101-6026
Telephone: (702) 385-4202

STANLEY M. CHESLEY, ESQ.
WAITE, SCHNEIDER, BAYLESS &
CHESLEY CO., L.P.A.
1513 Central Trust Tower
Fourth and Vine Streets
Cincinnati, OH 45202

JOHN L. CUMMINGS III, ESQ.
416 Gravier Street
New Orleans, LA 70130

ATTORNEYS FOR PLAINTIFFS

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO CV-S-89-249-PMP (L.R.L.)

MARY FORSYTH; MARRIETTA CADE; WILLIE ANDREWS; MARY LOU BUEHLER; HELEN STAVES; RANDOLPH BRATTON; and SEARLE AUTO GLASS, INC., doing business as BEST GLASS COMPANY,

Plaintiffs,

vs.

HUMANA, INC., a Delaware corporation; HUMANA HEALTH INSURANCE OF NEVADA, INC., a Nevada corporation; and DOE CORPORATIONS I through V, inclusive,

Defendants.

AMENDED COMPLAINT AND JURY DEMAND

COME NOW, Plaintiffs Mary Forsyth, Marrietta Cade, Willie Andrews, Mary Lou Buehler, Helen Staves, Randolph Bratton and Searle Auto Glass, Inc., d/b/a Best Glass Co., by and through their counsel of record, Jones, Jones, Close & Brown, Chartered, Waite, Schneider, Bayless & Chesley Co., L.P.A.; and John L. Cummings III, Esq. and for their causes of action against Defendants complain, aver and allege as follows:

JURISDICTION AND VENUE

1. This action arises under the laws of the United States and includes claims for relief under 29 U.S.C. § 1001, *et seq.*, the Employment Retirement Income Security Act ("ERISA"); these proceedings are also instituted against the above-named Defendants Humana, Inc. and Humana Health Insurance, Inc., under Section 4 and 16 of the Clayton Act (15 U.S.C. § § 15 and 26) to secure damages from and injunctive relief against Humana for its violations of Section 2 of the Sherman Act (15 U.S.C. § 2) as hereinafter alleged; these proceedings are also instituted under 18 U.S.C. § 1961 - 1968.. Subject matter jurisdiction is conferred upon this Court by 29 U.S.C. § 1132, 15 U.S.C. § 15 & 16, and 28 U.S.C. § 1337.

2. Venue of this action is proper in this Court pursuant to 15 U.S.C. § 15, 28 U.S.C. § 1391 and 29 U.S.C. § 1132.

3. Defendants above named maintain an office and transact business and may be found within the District of Nevada. The interstate trade and commerce involved and affected by the alleged violations of the antitrust laws is carried on, in part, within the District of Nevada.

PARTIES

4. Plaintiff Mary Forsyth resides at 4625 East Twain Street, Las Vegas, Nevada 89121. In 1986 Ms. Forsyth was

insured with Humana Care Plus through her employer, Kreel Printing. Ms. Forsyth paid a portion of the insurance premiums for her insurance with Defendant Humana Health Insurance of Nevada, Inc., ("Humana-Insurance") through payroll deductions.

5. Plaintiff Marrietta Cade, 4433 West Lake Mead Boulevard, Las Vegas, Nevada has been insured with Humana-Insurance since 1985. Marrietta Cade worked for many years at the Las Vegas Sun. Mrs. Cade terminated her employment in December 1988. Marrietta Cade was at all times relevant Humana-Insurance insured and currently remains personally insured with Humana Care Plus paying a monthly premium of approximately $355.00 per month. Her husband, Robert Cade, was a dependent under her Humana-Insurance policy. Robert Cade was hospitalized at Humana Hospital Sunrise between October 7, 1987 and October 17, 1987. The Cades incurred a hospital bill of $16,437.66. Mrs. Cade paid co-payments for her husband's hospitalization.

6. Plaintiff Willie Andrews, 804 McWilliams Street, Las Vegas, Nevada 89106, has been insured with Humana Care Plus since May 1985. At all times relevant, Ms. Andrews was employed with the Clark County School District and did make premium payments through her employer. Ms. Andrews was hospitalized from November 4, 1986 through November 9, 1986. Ms. Andrews, under the 20% co-payment provisions, was obligated to pay and did pay a portion of all of her hospitalization costs.

7. Plaintiff Mary Lou Buehler, 210 Meyers Avenue, Henderson, Nevada 89015, has been insured with Humana-Insurance since 1984. She is insured through her husband's employer, Cashman Cadillac. Through her husband, a dependent premium was paid of approximately $140.00 per month for her coverage. In September 1987 and again in

October of 1988 Mrs. Buehler was hospitalized for a total of approximately fourteen days. Her billings for those hospitalizations were $23,293.94 and $2,736.85, respectively. Under the co-payment provision of her policy she was obligated to pay 20% of the costs of her hospitalization. Ms. Buehler has paid a portion of the co-payment.

8. Plaintiff Helen Staves, 37 East Stewart, Unit 50, Las Vegas, Nevada 89110, has been insured with Humana-Insurance since July 1988. At all times relevant, Mrs. Staves was employed at the Dunes Hotel and made separate monthly premium payments of $40.00 per pay period for her policy of health insurance with Humana-Insurance. In October 1988 Ms. Staves was hospitalized at Humana Hospital Sunrise. Pursuant to the co-payment provisions under her policy, she is required to pay 20% of the costs of that hospitalization. Her expenses incurred for that hospitalization were $14,764.35. Mrs. Staves paid her portion of the co-payment.

9. Plaintiff Randolph Bratton, P.O. Box 175, State Route 38, Las Vegas, Nevada 89124 has been insured with Humana-Insurance since 1985. Between 1985 and August of 1987, Mr. Bratton was employed by the Las Vegas Sun. Since August 1987, Mr. Bratton has been employed by the Clark County School District. At all times relevant, Mr. Bratton was an insured of Humana-Insurance. On February 12, 1988, Mr. Bratton was admitted to Humana Hospital Sunrise At that time day surgery was performed and he incurred a hospital bill of approximately $1,400.00. Mr. Bratton remains obligated to make the 20% co-payment.

10. None of the individual Plaintiffs above-named were ever informed that Humana-Insurance was able to negotiate favorable hospitalization rates at Humana Hospital Sunrise or that Humana-Insurance negotiated such rates for itself.

11. Plaintiff Searle Auto Glass, Inc., doing business as Best Glass Co. (''Best Glass''), 1225 S. Commerce Street, Las Vegas, Nevada 89102, is a Nevada corporation in good standing. Best Glass has utilized Humana-Insurance to provide health insurance to its employees between the years 1985 and 1988, inclusive. Best Glass' group number with Humana-Insurance is 8280[illegible]8351-001. When Best Glass first became an insured with Humana-Insurance, the rates were very reasonable, $64.23 per employee per billing period. In 1986 this rate increased by 3% and in 1987 the rate jumped 13%. Finally, in 1988, when Best Glass decided not to renew with Humana-Insurance, Humana-Insurance sought a premium increase of 41% to continue coverage of employees of Best Glass. At no time did Humana-Insurance ever inform Best Glass that it was able to negotiate favorable hospitalization rates for its employees using Humana Hospital Sunrise for hospitalizations or that Humana-Insurance negotiated such rates for itself.

12. Defendant Humana Health Insurance of Nevada, Inc. (''Humana-Insurance'') is a corporation organized and existing under the laws of the State of Nevada with its principal place of business in Las Vegas, Nevada. Humana-Insurance is wholly owned subsidiary of Humana through Humana's ownership of Group Health Insurance, Inc. (''Group Health''). Humana-Insurance markets and sells group health insurance through employee benefit plans to employees throughout the State of Nevada, but with its principal geographic market being the Southern Nevada market, an area that includes portions of Southern California, Arizona and Utah.

13. Defendant Humana, Inc. (''Humana'') is a corporation organized and existing under the laws of the State of Delaware, with its principal place of business in Louisville, Kentucky. Humana is, and has for many years, been one of the largest owners and operators of acute care hospitals in

the United States. It owned and operated approximately 87 hospitals and health care facilities in 1986, one of which was Humana-Sunrise Hospital in Las Vegas, Nevada. Although Humana-Sunrise Hospital was only one of Humana's 87 hospitals in 1986, according to Humana's 1986 report to its stockholders, Humana-Sunrise generated 6.6 percent of Humana's gross revenue; and according to documents filed with the Nevada Department of Humana Resources in 1986, Humana-Sunrise generated thirty eight percent (38%) of Humana's pre-tax profits.

14. The true names and capacities, whether individual, corporate, associate, or otherwise, of Defendants herein designated as DOE CORPORATIONS I through V, inclusive, are unknown to Plaintiffs at this time, who therefore sue said Defendants by such fictitious names. Plaintiffs are informed and believe and thereon allege that each of said Defendants is responsible in some manner for the events and happenings and proximately caused the injuries and damages herein alleged. Plaintiffs will seek leave to amend this Complaint to allege their true names and capacities when and as ascertained.

CLASS ACTION

15. By order of this Court on September 26, 1989 Plaintiffs Willie Andrews, Randolph Bratton, Marrietta Cade, Mary Lou Buehler and Helen Staves (the ''Co-Payor Class'') were recognized as class representatives pursuant to Fed.R.Civ.Pro. 23(b)(3).

16. By order of this court on September 26, 1989, Plaintiff Mary Forsyth, Marrietta Cade, Willie Andrews, Helen Staves and Searle Auto Glass, Inc. (the ''Anti-Trust Class'') were recognized as class representatives pursuant to Fed.R.Civ.Pro. 23(b)(3). This Anti-Trust Class consists of individuals or entities paying at least a portion of the Humana-Insurance premiums during the relevant times.

CLASS ACTION

FIRST CLAIM FOR RELIEF

(Breach of ERISA Fiduciary Duties;
Engaging in Prohibited Transactions;
and Retaining Excessive Compensation)

17. The Co-Payor class reasserts and realleges each and every allegation contained in paragraphs 1 through 16 of the Complaint as though fully set forth at this point.

18. The Co-Payor Class consists of employees obtaining health insurance benefits under the employee benefit plan as defined under 29 U.S.C. 1001 *et seq*.

19. The members of the Co-Payor Class incurred charges at Humana Hospital Sunrise for hospitalization and were obligated to or did pay a portion of the hospital charges. Defendant Humana-Insurance is the insurer of the members of the Co-Payor Class through its insurance plan, Humana Care Plus.

20. The Humana Care Plus policy required that each member of the Co-Payor Class pay 20% of hospital costs. Humana-Insurance agreed to pay the remaining 80% of the hospital charges. The Co-Payor Class believed, and their agreement with Humana-Insurance provided, that the members of the Co-Payor Class and Humana-Insurance would be paying their respective contractual percentage of the charges.

21. Humana and Humana-Insurance negotiated a secret agreement which greatly reduced or discounted hospital charges for Humana-Insurance patients incurring charges at Humana Hospital Sunrise which constitutes discretionary authority and discretionary control respecting management of the plan, discretionary authority and discretionary control respecting management or disposition of its assets, or discre-

tionary authority or discretionary responsibility in the administration of the plan. Humana-Insurance is a fiduciary as defined under 29 U.S.C. § 1001(21)(A).

22. The agreement Humana-Insurance negotiated with Humana specifically provided for the insurance company to pay the hospital based on a discounted rate while the insureds were to pay based on the usual and customary rate.

23. Humana-Insurance exercised discretionary authority during the aforementioned negotiations with Humana. The reduced or discounted hospital charges were a crucial part of the administration of the health care plan.

24. Defendant Humana-Insurance has breached its fiduciary duties to all members of the Co-Payor Class in that it has failed to pass along the reduced costs it was able to negotiate with Humana in the form of reduced co-payments. 29 U.S.C. § 1004.

25. Defendant Humana-Insurance has breached its fiduciary duties to all members of the Co-Payor Class in that it has failed to refund the discount of the reduced costs it was able to negotiate with Humana. 29 U.S.C. § 1104.

26. Defendant Humana-Insurance has breached its fiduciary duties to all members of the Co-Payor Class by breaching its duty to accomplish the exclusive purpose of providing benefits to participants and by failing to defray the reasonable expenses necessary for the administration of the plan. Humana-Insurance imprudently decided to retain the co-payment refunds it negotiated with Humana. Humana-Insurance received excessive compensation in violation of its fiduciary duties. 29 U.S.C. § 1104.

27. Defendant Humana-Insurance has breached its fiduciary duties to all members of the Co-Payor Class by failing to adhere to the documents and instruments governing the plan, including but not limited to, AB 289. 29 U.S.C. § 1104.

28. Defendant Humana-Insurance engaged in prohibited transactions in violation of its fiduciary duties by dealing with the assets of the plan in its own interest or for its own account. 29 U.S.C. § 1106.

29. Defendant Humana-Insurance engaged in prohibited transactions in violation of its fiduciary duties by acting on behalf of Humana whose interests are adverse to the interests of the plan or the Co-Payor Class. Humana-Insurance was prohibited from even negotiating the co-payment amount with its related entity Humana. 29 U.S.C. § 1106.

30. Defendant Humana-Insurance engaged in prohibited transactions in violation of its fiduciary duties by unlawfully receiving consideration for its own personal account in connection with a transaction involving the assets of the plan. 29 U.S.C. § 1106.

31. It would be wrongful for Humana-Insurance to retain monies, in excess of those it might otherwise have been entitled to, when such monies have been obtained wrongfully and in breach of Humana-Insurance's duties to the Co-Payor Class and agreement with the Co-Payor Class.

32. A constructive trust should be imposed on the Defendants which requires turnover of all monies obtained through the scheme described herein.

33. Plaintiffs should be named the beneficiaries of the constructive trust awarded by this Court.

34. As a result of the Defendants' unlawful and/or inequitable scheme heretofore alleged, Plaintiffs have conferred a monetary benefit upon Defendant Humana-Insurance. Defendant Humana-Insurance appreciated and realized the monetary benefit and accepted and retained the monetary benefit under circumstances such that it would be inequitable for Humana-Insurance to retain the monetary benefit without returning the benefit to the Co-Payor Class. As a result of

the scheme, the Defendant Humana-Insurance was unjustly enriched, all to the detriment of the Co-Payor Class.

35. The acts and practices of Humana-Insurance as set forth and described herein are reasonably likely to continue in the future and cause further injury and damage to Plaintiffs unless restrained by order of this Court, and therefore the Co-Payor Class is entitled to a permanent injunction against Humana-Insurance.

36. The Co-Payor Class has been damaged as a result of the breach of ERISA fiduciary duties by Humana-Insurance, but the Co-Payor Class cannot now measure the damages with sufficient specificity but estimate these damages to be in excess of $10,000,000.00.

37. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered; Waite, Schneider, Bayless & Chesley Co., L.P.A.; and John L. Cummings III, Esq., to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor. 29 U.S.C. § 1132(g).

SECOND CLAIM FOR RELIEF

(Anti-Trust)

38. Plaintiffs reassert and reallege each and every allegation contained in paragraphs 1 through 37 of the Complaint as though fully set forth at this point.

39. This Premium-Payor Class consists of individuals or entities paying all or a portion of the Humana-Insurance premiums during the period 1985 to 1988, including but not limited to employers who made insurance premium payments on behalf of their employees, as well as individual employees who either directly paid insurance premiums on behalf of their dependents, or who did so indirectly by such means as payroll deductions by their employers.

40. Defendant Humana is in the business of owning and operating for-profit acute care health facilities. Humana owns and operates a for-profit acute care health facility named Humana-Sunrise Hospital which provides a full range of hospital services within Clark County, Nevada. Approximately sixty percent (60%) of the gross charges for all patients hospitalized in major for-profit acute care facilities in Clark County, Nevada were billed by Humana-Sunrise Hospital in the relevant time period. This percentage is, and at all times relevant hereto has been, the largest market share of any for profit acute care facility in Clark County, Nevada.

41. At all times relevant hereto, the hospital charges billed by Humana for hospitalization at Humana-Sunrise were anti-competitively high compared to comparable geographic markets. In 1986, the State of Nevada had the highest per patient day billed charges in the United States and Humana-Sunrise had the highest per patient day billed charges in the State of Nevada; i.e., $1,617 per patient day. At all times relevant hereto, the percentage return on investment at Humana-Sunrise was anti-competitively high compared to comparable geographic markets. In 1986, Humana-Sunrise possessed a 37.44% return on investment. At all times relevant hereto, the profit margin of Humana-Sunrise was anti-competitively high compared to comparable geographic markets. In 1986, Humana-Sunrise possessed a profit margin of 36% compared to a national average of 14.4%.

42. In 1984, Humana, through its wholly-owned subsidiary, GROUP HEALTH, began to market and sell group health insurance policies in Clark County, Nevada. Aforesaid policies were sold through organized advertising activities in Clark County, Nevada, by means of newspaper advertisements, radio advertisements and television advertisements. GROUP HEALTH marketed and sold such policies

through its wholly-owned subsidiary Humana-Insurance using public advertising and private solicitation. In utilizing the above-described marketing scheme, Humana did so for the primary purpose of maintaining Humana's dominant market share of the gross charges from all patients hospitalized in major for-profit acute care facilities in Clark County, Nevada by maintaining or increasing the number of patients utilizing Humana-Sunrise.

44. Humana and Humana-Insurance controlled the pricing mechanisms for the per diem charges for inpatient hospitalization and hospital services billed by Humana and for Humana group health policies. Humana and Humana-Insurance engaged in predatory pricing to give Humana an unlawful competitive advantage by allowing it to maintain, through revenues transmitted to its subsidiary by secret discounts, an anti-competitively high profit by maintaining or increasing the number of patients and in addition, by providing Humana-Insurance with a significantly lower per diem charge. As a result of aforesaid unlawful efforts to maintain or increase its market share and also as a result of aforesaid predatory pricing, Humana successfully and wilfully maintained its overwhelming percentage of the gross charges for all patients hospitalized in major for-profit acute care facilities in Clark County, Nevada.

45. The insurance agreement sold and marketed by Humana-Insurance through public advertising and private solicitation required its insureds to pay all expenses up to the designated deductible amount, and twenty percent (20%) of all expenses beyond the deductible; Humana-Insurance was required to pay the remaining eighty percent (80%) beyond the deductible.

46. Humana (Humana-Sunrise) and Humana-Insurance entered into a secret agreement in 1984 pursuant to which Humana-Insurance would pay Humana a discounted amount

for the portion of the per diem hospital charges for which it was responsible. No comparable discount was provided to other group health insurers. No comparable discount was provided on that portion of the charges paid by the insureds. Humana and Humana-Insurance agreed to keep this agreement secret from the Premium-Payor Class, the general public and state agencies.

47. Since at least 1984, and to and including the date of the filing of this Complaint, Humana and Humana-Insurance have violated Section 2 of the Sherman Act (15 U.S.C. § 2) by monopolizing or attempting to monopolize the provision of major for-profit acute care facilities in Clark County, Nevada.

48. In furtherance of the aforesaid monopolization and attempt to monopolize, Defendant Humana and Humana-Insurance have developed a mutually supportive system to engage in specific unlawful acts and practices for the express purpose of maintaining anti-competitively high hospital profits in the provision of for-profit acute care hospital services in Clark County, Nevada or for the express purpose of establishing a dominant market share for the provision of Group Health Care Policy insurance, the latter which market share was used as a mechanism for maintaining or increasing the patients for acute hospital care services at Humana-Sunrise. Aforesaid specific unlawful acts and practices include, but are not limited to the following:

A. Promoting the use of Humana-Sunrise Hospital's services instead of other hospitals through Humana Care Plus insurance policies offered by Humana-Insurance by requiring extensive penalties for insureds who failed to use Humana-Sunrise Hospital. These penalties include, but are not limited to the following:

1. Requiring a different and punitive deductible for obtaining services from non-Humana for-profit acute care hospitals;

2. Requiring a different and punitive co-payment for obtaining services from non-Humana for-profit acute care hospitals;

3. Applying a different standard of review when evaluating and paying claims from non-Humana for-profit acute care hospitals. Humana-Insurance systematically denied certain items of non-Humana hospitalization claims prolonged the time of payment for non-Humana hospitalization claims and prolonged the appeal process time of non-Humana hospitalization claims.

B. Humana engaged in a pattern of predatory pricing by offering Humana-Insurance an unreasonable discount not extended to other group health care insurance entities in the Clark County, Nevada area and not extended to persons or entities paying co-payments. This unlawful behavior bestowed upon Humana an unlawful anti-competitive advantage by allowing it to collect co-payments from patients and non-Humana insurance group health insurers based on the purported per diem. At the same time, this unlawful behavior bestowed a further unlawful anti-competitive advantage upon Humana by allowing it to limit its purported profits by the discounted per diem extended to Humana-Insurance, thereby evading the ceiling upon Humana's profits which would have been imposed by cost-containment legislation. This unlawful behavior also bestowed an unlawful anti-competitive advantage upon Humana-Insurance by charging it less per diem than other group health insurers were charged by Humana;

C. Humana's wholly owned subsidiary Humana-Insurance offered premium rates for group health insurance policies that are anti-competitively high compared to premium rates in comparable geographic markets

because of the anti-competitively high charges for hospital services in Clark County, Nevada, compared to comparable geographic markets;

D. Humana's wholly-owned subsidiary Humana-Insurance offered premium rates for group health insurance policies above reasonable actuarial practices would have determined based on the predatory discounted per diem charge that it received but which was not extended to other group health insurers or co-payors;

E. While the premium rates for health insurance policies offered by Humana-Insurance were anti-competitively high compared to premium rates in comparable geographic markets, Humana-Insurance initially engaged in predatory pricing within the Clark County market itself by attempting to under-cut the charges by other group health insurers in the Clark County market. The express purpose of this initial predatory pricing was to obtain market share for the Humana group health policy. After successfully acquiring market share through the initial predatory pricing, Humana-Insurance then raised its premiums; and

F. Humana or Humana-Insurance provided predatory incentives to persons or entities selling Humana-Insurance group health care policies, including advance payments of compensation;

49. By means of the acts hereinabove described, Humana and Humana-Insurance have acquired or maintained or attempted to acquire and maintain a monopoly on for-profit acute care hospital services in Clark County, Nevada and Humana and Humana Health Insurance have attempted to acquire and preserve a dominant market share for the provision of Group Health Care Policy insurance in the Clark County, Nevada area, the latter which dominant market share was used as a mechanism for maintaining or increasing

the patients for acute hospital care services at Humana-Sunrise.

50. As a direct and proximate result of the anti-competitive actions hereinabove recited, and as intended by Defendant Humana and Humana-Insurance, the Anti-Trust Class has sustained damages in that it was required to pay anti-competitively high premiums for group health care policies in the Clark County geographic market compared to premiums charged for comparable group health policies in comparable geographic markets and in that it was required to pay anti-competitively high co-payments based on the anti-competitively high hospital charges billed by Humana.

51. Plaintiffs cannot now measure these damages with sufficient specificity to allege the dollar amount thereof, but estimates the damage to be in excess of $10,000,000.00, before trebling. When Plaintiffs have sufficient information which would enable them to allege their damages with more specificity, Plaintiffs will seek leave of the Court to amend their Complaint to insert said sum or, in the alternative, will prove such damages at trial.

52. The anti-competitive acts and practices of Humana and Humana-Insurance as set forth and described herein are reasonably likely to continue in the future and to cause further injury and damage to Plaintiffs unless restrained by order of this Court.

53. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered; Waite, Schneider, Bayless & Chesley Co., L.P.A.; and John L. Cummings III, Esq., to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor.

THIRD CLAIM FOR RELIEF

(18 U.S.C. § 1961-1968)

54. Plaintiffs reassert and reallege each and every obligation contained in paragraphs 1 through 52 of the Amended Complaint as though fully set fourth at this point.

55. As part of a scheme to defraud Plaintiffs by charging Plaintiffs a different per diem per patient day on their co-payments, Humana and Humana-Insurance entered into a secret agreement (the "Agreement"). Pursuant to the Agreement, Humana-Insurance agreed to pay Sunrise Hospital a discounted amount for that portion of the hospital charges for which it was responsible. The portion of the charges paid by others, however, was not discounted but was still based on the usual and customary rate.

56. Premiums were not reduced by Humana-Insurance in the amount discounted. It was part of the scheme to defraud that Humana and Humana-Insurance used false and fraudulent pretenses, representations and promises calculated to deceive persons of ordinary prudence and due care and make material nondisclosures and concealment of fact and information important to the insureds (including but not limited to the existence of the secret agreement and the fact that Humana was billing Humana-Insurance at a different per diem) all so as to unlawfully, intentionally and wilfully, and with the intent to defraud, that is, knowingly and with specific intent to deceive in order to cause financial gain to themselves, procure secret profits to the use and benefit of themselves and others and to the detriment of the insureds consisting of the named Plaintiffs, as representatives of a class pursuant to Fed.R.Civ.Pro. Rule 23.

57. The scheme to defraud evolved over time a pattern of illegal activity that inflicted discreet harms on the insureds and others. The insureds, as victims of the unlawful patterns

of illegal activity, also suffered discreet losses as a result of these activities. The multifarious illegal activities through which the broad objectives of Humana and Humana-Insurance were carried out consisted of a complex pattern of individual transactions and group transactions. In carrying out the scheme to defraud, Defendants, Humana and Humana-Insurance engaged, *inter alia,* in conduct in violation of federal laws, to wit: 18 U.S.C. Section 1341; 18 U.S.C. Section 1343; and 18 U.S.C. § 664, as stated below:

(A) *18 U.S.C. Section 1341.* As part of the false and fraudulent scheme to defraud, Defendant Humana and/or Defendant Humana-Insurance, caused to be sent through the United States mail explanations of benefits, patient account statements, itemized statements, demand letters and other correspondence in order to collect co-payments from insureds for hospital charges as SUNRISE Hospital. Defendant Humana and/or Defendant Humana-Insurance, did not inform the insureds that Humana and Humana-Insurance had entered into an agreement specifically providing for the insurance company to pay the hospital based on a discounted rate while the insureds were to pay based on the usual and customary rate. This material nondisclosure and concealment of facts and information from the insureds was intentionally and knowingly conceived in order to deceive the insured and obtain financial gain. This use of the United States mail in furtherance of the false and fraudulent scheme violates 18 U.S.C. Section 1341.

(B) *18 U.S.C. Sections 1343.* As part of the false and fraudulent scheme to defraud, Defendant Humana and/or Defendant Humana-Insurance, caused to be sent through radio and television transmissions, advertising promoting the Humana group health policy as part of the false and fraudulent scheme to defraud, Defendants further used the telephone lines to explain or discuss billing in order to collect co-payments from insureds for hospital charges at Sunrise

Hospital. Defendant Humana and/or Defendant Humana-Insurance, did not inform the insureds that Humana and Humana-Insurance entered into an agreement specifically providing for the insurance company to pay the hospital based on a discounted rate while the insureds were to pay based on the usual and customary rate. This material nondisclosure and concealment of fact and information to the insureds was intentionally and knowingly conceived in order to deceive the insured and obtain financial gain. This violates 18 U.S.C. Section 1343.

(C) *18 U.S.C. § 664.* As part of the false and fraudulent scheme the defraud, Defedant Humana and/or Defendant Humana-Insurance unlawfully and willfully converted co-payments and premiums to their own use. By failing to bill the co-payor class at a discounted rate, Humana converted these funds to its own use. By failing to pass along premium reductions, Humana-Insurance converted these funds to its own use. 18 U.S.C. § 664 explicitly provides that any person who "unlawfully and willfully abstracts or converts to his own use or to the use of another, any of the . . . premiums . . . of any employee welfare plan . . . ." shall be fined not more than $10,000, or imprisoned not more than five years, or both.

58. The Plaintiffs and the members of the designated class which they represent are each a "person" within the meaning of 18 U.S.C. § 1961(3) and § 1964(c).

59. Defendant Humana is a "person" within the meaning of 18 U.S.C. § 1963(3) and § 1964(c). Defendant Humana-Insurance is an "enterprise" within the meaning of 18 U.S.C. § 1961(4) and § 1962(c), which enterprise was engaged in and the activities of which affected interstate commerce during the relevant times. Defendant Humana was associated with an enterprise, that is, Humana-Insurance, and did conduct or participate directly or indirectly, in the

conduct of the affairs of Humana-Insurance through a pattern of activity within the meaning of 18 U.S.C. § 1961 (1)(B), 1961(5) and 1962(c), to-wit:

(a) Multiple instances of in violations of 18 U.S.C. § 1341;

(b) Multiple instances in violation of 18 U.S.C. § 1433; and

(c) Multiple instances of ERISA violations of 18 U.S.C. § 664.

60. Defendant Humana did use or invest, directly or indirectly, part of income derived, directly or indirectly, from a pattern of activity in the acquisition of any interest, income, or the establishment or operation of an enterprise, that is, Humana-Insurance, within the meaning of 18 U.S.C. § 1961(1)(B), and § 1961(5) and § 1962(a), to-wit:

(a) Multiple instances of violations of 18 U.S.C. § 1341;

(b) Multiple instances of violations of 18 U.S.C. § 1433; and

(c) Multiple instances of ERISA violations of 18 U.S.C. § 664.

61. Humana and Humana-Insurance are an association in fact which constitute an "enterprise" within the meaning of 18 U.S.C. § 1961(4) and § 1962(a), which enterprise was engaged in and the activities which affected interstate commerce during the relevant times.

62. Defendant Humana did use or invest, directly or indirectly, income derived, directly or indirectly, from a pattern of unlawful activity in the acquisition of any interest in or the establishment or operation of an enterprise, that is, the association in fact comprised of Humana and Humana-

Insurance, within the meaning of 18 U.S.C. § 1961(1)(B), and § 1961(5) and § 1962(a), to-wit:

(a) Multiple instances of mail fraud in violations of 18 U.S.C. § 1341;

(b) Multiple instances of wire fraud in violations of 18 U.S.C. § 1343; and

(c) Multiple instances of ERISA violations of 18 U.S.C. § 664.

63. By reason of the violations of 18 U.S.C. § 1962(c) § 1962(9) committed by Defendants Humana, the Plaintiffs and the members of the designated class which they represent were injured in an as yet undetermined amount, believed to be in excess of $10,000,000.00 within the meaning of 18 U.S.C § 1964(c) When Plaintiffs have sufficient information which would enable them to allege their damages with more specificty, Plaintiffs will seek leave of the Court to amend their Complaint to insert said sum or, in the alternative, will prove such damages at trial.

64. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered; Waite, Schneider, Bayless & Chesley Co., L.P.A.; and John L. Cummings III, Esq., to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor.

WHEREFORE, Plaintiffs pray for judgment against Defendants, jointly and/or severally, where applicable in each claim for relief as follows:

1. An amount in excess of $10,000,000.00 based upon the ERISA violations by Humana-Insurance on the First Claim for Relief.

2. A constructive trust be imposed in the amount of all monies received as a result of the scheme, with Plaintiffs to be named as the beneficiaries of the trust on the First Claim for Relief.

3. For declaratory judgment and permanent injunction establishing the rights and duties between the parties and for judgment requiring Humana-Insurance to cease and desist from the wrongful conduct described in the First Claim for Relief.

4. For general, special, and compensatory damages in an amount in excess of $10,000,000.00, before trebling, on the Second Claim for Relief.

5. For declaratory judgment and permanent injunction requiring Defendant to cease and desist the wrongful conduct described in the Second Claim for Relief.

6. For general, special, and compensating damages in an amount in excess of $10,000,000.00 before trebbing, on the Third Claim for Relief.

7. For costs of suit and fees incurred herein.

8. For such further and other relief as the Court deems just and equitable.

DATED this 27th day of October, 1989.

/s/ J. Randall Jones
J. RANDALL JONES, ESQ.

/s/ Will Kemp
WILL KEMP, ESQ.

JONES, JONES, CLOSE & BROWN, CHARTERED
300 So. Fourth St., #700
Las Vegas, Nevada 89101

ATTORNEYS FOR PLAINTIFFS

Plaintiffs demand a trial by jury on all issues so triable.

/s/ J. Randall Jones
J. RANDALL JONES, ESQ.

/s/ Will Kemp
WILL KEMP, ESQ.

JONES, JONES, CLOSE & BROWN, CHARTERED
300 So. Fourth St., #700
Las Vegas, Nevada 89101

ATTORNEYS FOR PLAINTIFFS

J. RANDALL JONES, ESQ.
JONES, JONES, CLOSE
& BROWN, CHARTERED
700 Valley Bank Plaza
300 So. Fourth Street
Las Vegas, NV 89101-6026
Telephone: (702) 385-4202

STANLEY M. CHESLEY, ESQ.
WAITE, SCHNEIDER, BAYLESS &
CHESLEY CO., L.P.A.
1513 Central Trust Tower
Fourth and Vine Streets
Cincinnati, OH 45202

JOHN L. CUMMINGS III, ESQ.
416 Gravier Street
New Orleans, LA 70130

ATTORNEYS FOR PLAINTIFFS

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO CV-S-89-249-PMP (L.R.L.)

MARY FORSYTH; MARRIETTA CADE; WILLIE ANDREWS; MARY LOU BUEHLER; HELEN STAVES; RANDOLPH BRATTON; and SEARLE AUTO GLASS, INC., doing business as BEST GLASS COMPANY,

Plaintiffs,

vs.

HUMANA, INC., a Delaware corporation; HUMANA HEALTH INSURANCE OF NEVADA, INC., a Nevada corporation; and DOE CORPORATIONS I through V, inclusive,

Defendants.

ERRATA SHEET FOR AMENDED COMPLAINT

TO THE HONORABLE COURT:

NOW APPEARS, Plaintiffs, Mary Forsyth, Marrietta Cade, Willie Andrews, Mary Lou Buehler, Helen Staves, Randolph Bratton and Searle Auto Glass, Inc. d/b/a Best Glass Co., by and through their counsel of record, Jones, Jones, Close & Brown, Chartered, Waite, Schneider, Bayless & Chesley Co., L.P.A., and John L. Cummings III, Esq. and hereby informs the Court and Defendants that pp. 22 and 23 of the Amended Complaint filed on October 27, 1989, should be replaced by the attached pages. Replacement of pp. 22 and 23 are necessary to correct an inadvertent error.

DATED this 27th day of October, 1989.

/s/ J. Randall Jones
J. RANDALL JONES, ESQ.

JONES, JONES, CLOSE & BROWN, CHARTERED
300 So. Fourth St., #700
Las Vegas, Nevada 89101

ATTORNEYS FOR PLAINTIFFS

CERTIFICATE OF MAILING

I certify that on the 27th day of October, 1989, the Amended Complaint and Jury Demand was served upon Defendants by mailing a copy thereof, first class mail, postage prepaid, to:

Thomas H. Brock, Esq.
Burton J. Fishman, Esq.
Michael F. Moses, Esq.
CASSON, HARKINS & LAPALLO
1233 20th Street, N.W., Suite 800
Washington, D.C. 20036

/s/ Wendi Perkins
An employee of JONES, JONES, CLOSE & BROWN, CHARTERED

RECEIPT OF COPY

RECEIPT of a true and correct copy of the within ERRATA SHEET FOR AMENDED COMPLAINT is hereby acknowledged on this 30 day of October, 1989.

LIONEL SAWYER & COLLINS

By: /stamp/ Paul R. Hejmanowski
PAUL R. HEJMANOWSKI, ESQ.
300 South Fourth Street
Suite 1700
Las Vegas, Nevada 89101

"enterprise" within the meaning of 18 U.S.C. § 1961(4) and § 1962(c), which enterprise was engaged in and the activities of which affected interstate commerce during the relevant times. Defendant Humana was associated with an enterprise, that is, Humana-Insurance, and did conduct or participate directly or indirectly, in the conduct of the affairs of Humana-Insurance through a pattern of activity within the meaning of 18 U.S.C. § 1961(1)(B), 1961(5) and 1962(c), to-wit:

(a) Multiple instances of in violations of 18 U.S.C. § 1341;

(b) Multiple instances in violation of 18 U.S.C. § 1433; and

(c) Multiple instances of violations of 18 U.S.C. § 664.

60. Defendant Humana did use or invest, directly or indirectly, part of income derived, directly or indirectly, from a pattern of activity in the acquisition of any interest, income, or the establishment or operation of an enterprise, that is, Humana-Insurance, within the meaning of 18 U.S.C. § 1961(1)(B), and § 1961(5) and § 1962(a), to-wit:

(a) Multiple instances of violations of 18 U.S.C. § 1341;

(b) Multiple instances of violations of 18 U.S.C. § 1433; and

(c) Multiple instances of violations of 18 U.S.C. § 664.

61. Humana and Humana-Insurance are an association in fact which constitute an "enterprise" within the meaning of 18 U.S.C.

§ 1961(4) and § 1962(a), which enterprise was engaged in and the activities which affected interstate during the relevant times.

62. Defendant Humana did use or invest, directly or indirectly, income derived, directly or indirectly, from a pattern of unlawful activity in the acquisition of any interest in or the establishment or operation of an enterprise, that is, the association in fact comprised of Humana and Humana-Insurance, within the meaning of 18 U.S.C. § 1961(1)(B), and § 1961(5) and § 1962(a), to-wit:

(a) Multiple instances of mail fraud in violations of 18 U.S.C. § 1341;

(b) Multiple instances of wire fraud in violations of 18 U.S.C. § 1343; and

(c) Multiple instances of violations of 18 U.S.C. § 664.

63. By reason of the violations of 18 U.S.C. § 1962(c) § 1962(9) committed by Defendants Humana, the Plaintiffs and the members of the designated class which they represent were injured in an as yet undetermined amount, believed to be in excess of $10,000,000.00 within the meaning of 18 U.S.C § 1964(c) When Plaintiffs have sufficient information which would enable them to allege their damages with more specificity, Plaintiffs will seek leave of the Court to amend their Complaint to insert said sum or, in the alternative, will prove such damages at trial.

64. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered; Waite, Schneider, Bayless & Chesley Co., L.P.A.; and John L. Cummings

J. RANDALL JONES, ESQ.
JONES, JONES, CLOSE
& BROWN, CHARTERED
700 Valley Bank Plaza
300 So. Fourth Street
Las Vegas, NV 89101-6026
Telephone: (702) 385-4202

STANLEY M. CHESLEY, ESQ.
WAITE, SCHNEIDER, BAYLESS &
CHESLEY CO., L.P.A.
1513 Central Trust Tower
Fourth and Vine Streets
Cincinnati, OH 45202

JOHN L. CUMMINGS III, ESQ.
416 Gravier Street
New Orleans, LA 70130

ATTORNEYS FOR PLAINTIFFS

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO CV-S-89-249-PMP (L.R.L.)

MARY FORSYTH; MARRIETTA CADE; WILLIE ANDREWS; MARY LOU BUEHLER; HELEN STAVES; RANDOLPH BRATTON; and SEARLE AUTO GLASS, INC., doing business as BEST GLASS COMPANY,

Plaintiffs,

vs.

HUMANA, INC., a Delaware corporation; HUMANA HEALTH INSURANCE OF NEVADA, INC., a Nevada corporation; and DOE CORPORATIONS I through V, inclusive,

Defendants.

NOTICE OF FILING AMENDED COMPLAINT

TO THE HONORABLE COURT:

NOW APPEARS, Plaintiffs, Mary Forsyth, Marrietta Cade, Willie Andrews, Mary Lou Buehler, Helen Staves, Randolph Bratton and Searle Auto Glass, Inc. d/b/a Best Glass Co., by and through their counsel of record, Jones, Jones, Close & Brown, Chartered, Waite, Schneider, Bayless & Chesley Co., L.P.A., and John L. Cummings III, Esq. and hereby informs the Court and Defendants that Plaintiffs have amended their complaint.

In open Court and in the Court's September 27, 1989 ruling on Defendants' recent motion to dismiss, this Honorable Court granted Plaintiffs leave to amend their complaint. Specifically, the Court allowed Plaintiffs' the right to plead more definite claims to conform with the Court's instructions regarding the ERISA and Anti-Trust claims. See September 27, 1989 Order, pp. 12-13, 17. Plaintiffs have amended their ERISA and Anti-Trust claims and have also added a claim for violation of 18 U.S.C. § 1961-1968 (RICO) in order to disclose other alleged violations by Defendants of federal laws.

Rule 15(a) of the Federal Rules of Civil Procedure explicitly states that Plaintiffs may amend their complaint once "as a matter of course at any time before a responsive pleading is served." Fed.R.Civ.P. 15(a). Defendants have not yet filed a "responsive pleading". Accordingly, Plaintiffs inform the Court and Defendants that they have amended their Complaint.

DATED this 27th day of October, 1989.

JONES, JONES, CLOSE
& BROWN, CHARTERED

By /s/ J. Randall Jones
J. RANDALL JONES, ESQ.
WILL KEMP, ESQ.
700 Valley Bank Plaza
300 So. Fourth Street
Las Vegas, NV 89101-6026

ATTORNEYS FOR PLAINTIFFS

RECEIPT OF COPY

RECEIPT of a true and correct copy of the within AMENDED COMPLAINT is hereby acknowledged on this 27 day of October, 1989.

LIONEL SAWYER & COLLINS

By: /stamp/ Paul R. Hejmanowski
PAUL R. HEJMANOWSKI, ESQ.
300 South Fourth Street
Suite 1700
Las Vegas, Nevada 89101

CERTIFICATE OF MAILING

I hereby certify that on the 27th day of October, 1989, the Notice of Filing Amended Complaint was served upon Defendants by mailing a copy thereof, first class mail, postage prepaid to:

Thomas H. Brock, Esq.
Burton J. Fishman, Esq.
Michael F. Moses, Esq.
CASSON, HARKINS & LAPALLO
1233 20th Street, N.W., Suite 800
Washington, D.C. 20036

/s/ Janet A. Slone
An employee of JONES, JONES,
CLOSE & BROWN, CHARTERED

J. RANDALL JONES, ESQ.
WILL KEMP, ESQ.
JONES, JONES, CLOSE
& BROWN, CHARTERED
700 Valley Bank Plaza
300 South Fourth Street
Las Vegas, NV 89101-6026
Telephone: (702) 385-4202

STANLEY M. CHESLEY, ESQ.
WAITE, SCHNEIDER, BAYLESS &
CHESLEY CO., L.P.A.
1515 Central Trust Tower
Fourth and Vine Streets
Cincinnati, OH 45202

JOHN L. CUMMINGS III, ESQ.
CUMMINGS, CUMMINGS & DUDENHEFER
416 Gravier Street
New Orleans, LA 70130

WENDELL GAUTHIER, ESQ.
GAUTHIER & MURPHY
3500 North Hullen Street
Metairie, LA 70002

ATTORNEYS FOR PLAINTIFFS

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO. CV-S-89-249-PMP (L.R.L.)

MARY FORSYTH; MARRIETTA CADE; WILLIE ANDREWS; MARY LOU BUEHLER; HELEN STAVES; RANDOLPH BRATTON; and SEARLE AUTO GLASS, INC., doing business as BEST GLASS COMPANY,

Plaintiffs,

vs.

HUMANA, INC., a Delaware corporation; HUMANA HEALTH INSURANCE OF NEVADA, INC., a Nevada corporation; and DOE CORPORATIONS I through X, inclusive,

Defendants.

SECOND AMENDED COMPLAINT AND JURY DEMAND

COME NOW, Plaintiffs Mary Forsyth, Marrietta Cade, Willie Andrews, Mary Lou Buehler, Helen Staves, Randolph Bratton and Searle Auto Glass, Inc., d/b/a Best Glass Co., by and through their counsel of record, J. Randall Jones and Will Kemp of Jones, Jones, Close & Brown, Chartered; Stanley M. Chesley of Waite, Schneider, Bayless & Chesley Co., L.P.A.; John L. Cummings III of Cummings, Cummings & Dudenhefer; and Wendell Gauthier of Gauthier & Murphy, and for their causes of action against Defendants complain, aver and allege as follows:

JURISDICTION AND VENUE

1. This action arises under the laws of the United States and includes claims for relief under 29 U.S.C. § 1001, *et seq.*, the Employment Retirement Income Security Act ("ERISA") these proceedings are also instituted against the above-named Defendants Humana, Inc. and Humana Health Insurance, Inc., under Section 4 and 16 of the Clayton Act (15 U.S.C. §§ 15 and 26) to secure damages from and injunctive relief against Humana for its violations of Section 2 of the Sherman Act (15 U.S.C. § 2) as hereinafter alleged; these proceedings are also instituted under 18 U.S.C. §§ 1961 - 1968. Subject matter jurisdiction is conferred upon this Court by 29 U.S.C. § 1132, 15 U.S.C. §§ 15 & 16, and 28 U.S.C. § 1337.

2. Venue of this action is proper in this Court pursuant to 15 U.S.C. § 15, 28 U.S.C. § 1391 and 29 U.S.C. § 1132.

3. Defendants above named maintain an office and transact business and may be found within the District of Nevada. The interstate trade and commerce involved and affected by the alleged violations of the antitrust laws is carried on, in part, within the District of Nevada.

PARTIES

4. Plaintiff Mary Forsyth resides at 4625 East Twain Street, Las Vegas, Nevada 89121. In 1986 Ms. Forsyth was insured with Humana Care Plus through her employer, Kreel Printing. Ms. Forsyth paid a portion of the insurance premiums for her insurance with Defendant, Humana Health Insurance of Nevada, Inc., ("Humana-Insurance") through payroll deductions.

5. Plaintiff Marrietta Cade, 4433 West Lake Mead Boulevard, Las Vegas, Nevada has been insured with Humana-Insurance since 1985. Marrietta Cade worked for many years at the Las Vegas Sun. Mrs. Cade terminated her employment in December 1988. Marrietta Cade was at all times relevant Humana-Insurance insured and currently remains personally insured with Humana Care Plus paying a monthly premium of approximately $355.00 per month. Her husband, Robert Cade, was a dependent under her Humana-Insurance policy. Robert Cade was hospitalized at Humana Hospital Sunrise between October 7, 1987 and October 17, 1987. The Cades incurred a hospital bill of $16,437.66. Mrs. Cade paid co-payments for her husband's hospitalization.

6. Plaintiff Willie Andrews, 804 McWilliams Street, Las Vegas, Nevada 89106, has been insured with Humana Care Plus since May 1985. At all times relevant, Ms. Andrews was employed with the Clark County School District and did make premium payments through her employer. Ms. Andrews was hospitalized from November 4, 1986 through

November 9, 1986. Ms. Andrews, under the 20% co-payment provisions, was obligated to pay and did pay a portion of all of her hospitalization costs.

7. Plaintiff Mary Lou Buehler, 210 Myers Avenue, Henderson, Nevada 89015, has been insured with Humana-Insurance since 1984. She is insured through her husband's employer, Cashman Cadillac. Through her husband, a dependent premium was paid of approximately $140.00 per month for her coverage. In September 1987 and again in, October of 1988 Mrs. Buehler was hospitalized for a total of approximately fourteen days. Her billings for those hospitalizations were $23,293.94 and $2,736.85, respectively. Under the co-payment provision of her policy, she was obligated to pay 20% of the costs of her hospitalization. Ms. Buehler has paid a portion of the co-payment.

8. Plaintiff Helen Staves, HCR 65, Box 71408, Pahrump, Nevada 89041, has been insured with Humana-Insurance since July 1988. At all times relevant, Mrs. Staves was employed at the Dunes Hotel and made separate monthly premium payments of $40.00 per pay period for her policy of health insurance with Humana-Insurance. In October 1988 Ms. Staves was hospitalized at Humana Hospital Sunrise. Pursuant to the co-payment provisions under her policy, she is required to pay 20% of the costs of that hospitalization. Her expenses incurred for that hospitalization were $14,764.35. Mrs. Staves paid her portion of the co-payment.

9. Plaintiff Randolph Bratton, P.O. Box 175, State Route 38, Las Vegas, Nevada 89124 has been insured with Humana-Insurance since 1985. Between 1985 and August of 1987, Mr. Bratton was employed by the Las Vegas Sun. Since August 1987, Mr. Bratton has been employed by the Clark County School District. At all times relevant, Mr. Bratton was an insured of Humana-Insurance. On February

12, 1988, Mr. Bratton was admitted to Humana Hospital Sunrise. At that time day surgery was performed and he incurred a hospital bill of approximately $1,400.00. Mr. Bratton remains obligated to make the 20% co-payment.

10. None of the individual Plaintiffs above-named were ever informed that Humana-Insurance was able to negotiate favorable hospitalization rates at Humana Hospital Sunrise or that Humana-Insurance negotiated such rates for itself.

11. Plaintiff Searle Auto Glass, Inc., doing business as Best Glass Co. (''Best Glass''), 1225 S. Commerce Street, Las Vegas, Nevada 89102, is a Nevada corporation in good standing. Best Glass has utilized Humana-Insurance to provide health insurance to its employees between the years 1985 and 1988, inclusive. Best Glass' group number with Humana-Insurance is 82801-18351-001. When Best Glass first became an insured with Humana-Insurance, the rates were very reasonable, $64.23 per employee per billing period. In 1986 this rate increased by 3% and in 1987 the rate jumped 13%. Finally, in 1988, when Best Glass decided not to renew with Humana-Insurance, Humana-Insurance sought a premium increase of 41% to continue coverage of employees of Best Glass. At no time did Humana-Insurance ever inform Best Glass that it was able to negotiate favorable hospitalization rates for its employees using Humana Hospital Sunrise for hospitalizations or that Humana-Insurance negotiated such rates for itself.

12. Defendant Humana Health Insurance of Nevada, Inc. (''Humana-Insurance'') is a corporation organized and existing under the laws of the State of Nevada with its principal place of business in Las Vegas, Nevada. Humana-Insurance is wholly owned subsidiary of Humana through Humana's ownership of Group Health Insurance, Inc. (''Group Health'') Humana-Insurance markets and sells group health insurance through employee benefit plans to employees

throughout the State of Nevada, but with its principal geographic market being the Southern Nevada market, an area that includes portions of Southern California, Arizona and Utah.

13. Defendant Humana, Inc. (''Humana'') is a corporation organized and existing under the laws of the State of Delaware, with its principal place of business in Louisville, Kentucky. Humana is, and has for many years, been one of the largest owners and operators of acute care hospitals in the United States. It owned and operated approximately 87 hospitals and health care facilities in 1986, one of which was Humana-Sunrise Hospital in Las Vegas, Nevada. Although Humana-Sunrise Hospital was only one of Humana's 87 hospitals in 1986, according to Humana's report to its stockholders, Humana-Sunrise generated 6.6 percent of Humana's gross revenue; and according to documents filed with the Nevada Department of Humana Resources in 1986, Humana-Sunrise generated thirty eight percent (38%) of Humana's pretax profits.

14. The true names and capacities, whether individual, corporate, associate, or otherwise, of Defendants herein designated as DOE CORPORATIONS I through V, inclusive, are unknown to Plaintiffs at this time, who therefore sue said Defendants by such fictitious names. Plaintiffs are informed and believe and thereon allege that each of said Defendants is responsible in some manner for the events and happenings and proximately caused the injuries and damages herein alleged. Plaintiffs will seek leave to amend this Complaint to allege their true names and capacities when and as ascertained.

CLASS ACTION

15. By order of this Court on September 26, 1989 Plaintiffs Willie Andrews, Randolph Bratton, Marrietta Cade,

Mary Lou Buehler and Helen Staves (the "Co-Payor Class") were recognized as class representatives pursuant to Fed. R. Civ. Pro. 23(b)(3).

16. By order of this court on September 26, 1989, Plaintiff Mary Forsyth, Marrietta Cade, Willie Andrews, Helen Staves and Searle Auto Glass, Inc. (the "Anti-Trust Class") were recognized as class representatives pursuant to Fed. R. Civ. Pro. 23(b)(3). This Anti-Trust Class consists of individuals or entities paying at least a portion of the Humana-Insurance premiums during the relevant times.

17. By order of this Court on July 10, 1991, Plaintiffs Marietta Cade, Willie Andrews, Mary Lou Buehler, Helen Staves, and Randolph Bratton (the "RICO Co-Payor Class") were recognized as class representatives pursuant to Fed. R. Civ. P. 23(b)(3).

18. By order of this Court on July 10, 1991, Plaintiffs Mary Forsyth, Marrietta Cade, Willie Andrews, Mary Lou Buehler, Helen Staves, Randolph Bratton, and Searle Auto Glass, Inc. (the "RICO Premium-Payor Class" were recognized as class representatives pursuant to Fed. R. Civ. P. 23(b)(3).

CLASS ACTION

FIRST CLAIM FOR RELIEF

(Breach of ERISA Fiduciary Duties;
Engaging in Prohibited Transactions;
and Retaining Excessive Compensation)

19. The Co-Payor class reasserts and realleges each and every allegation contained in paragraphs 1 through 18 of the Complaint as though fully set forth at this point.

20. The Co-Payor Class consists of employees obtaining health insurance benefits under the employee benefit plan as defined under 29 U.S.C. 1001 *et seq.*

21. The members of the Co-Payor Class incurred charges at Humana Hospital Sunrise for hospitalization and were obligated to or did pay a portion of the hospital charges. Defendant Humana-Insurance is the insurer of the members of the Co-Payor Class through its insurance plan, Humana Care Plus.

22. The Humana Care Plus policy required that each member of the Co-Payor Class pay 20% of hospital costs. Humana-Insurance agreed to pay the remaining 80% of the hospital charges. The Co-Payor Class believed, and their agreement with Humana-Insurance provided, that the members of the Co-Payor Class and Humana-Insurance would be paying their respective contractual percentage of the charges.

23. Humana and Humana-Insurance negotiated a secret agreement which greatly reduced or discounted hospital charges for Humana-Insurance patients incurring charges at Humana Hospital Sunrise which constitutes discretionary authority and discretionary control respecting management of the plan, discretionary authority and discretionary control respecting management or disposition of its assets, or discretionary authority or discretionary responsibility in the administration of the plan. Humana-Insurance is a fiduciary as defined under 29 U.S.C. § 1001(21)(A).

24. The agreement Humana-Insurance negotiated with Humana specifically provided for the insurance company to pay the hospital based on a discounted rate while the insureds were to pay based on the usual and customary rate.

25. Humana-Insurance exercised discretionary authority during the aforementioned negotiations with Humana. The reduced or discounted hospital charges were a crucial part of the administration of the health care plan.

26. Defendant Humana-Insurance has breached its fiduciary duties to all members of the Co-Payor Class in that it has failed to pass along the reduced costs it was able to negotiate with Humana in the form of reduced co-payments. 29 U.S.C. § 1004.

27. Defendant Humana-Insurance has breached its fiduciary duties to all members of the Co-Payor Class in that it has failed to refund the discount of the reduced costs it was able to negotiate with Humana. 29 U.S.C. § 1104.

28. Defendant Humana-Insurance has breached its fiduciary duties to all members of the Co-Payor Class by breaching its duty to accomplish the exclusive purpose of providing benefits to participants and by failing to defray the reasonable expenses necessary for the administration of the plan. Humana-Insurance imprudently decided to retain the co-payment refunds it negotiated with Humana. Humana-Insurance received excessive compensation in violation of its fiduciary duties. 29 U.S.C. § 1104.

29. Defendant Humana-Insurance has breached its fiduciary duties to all members of the Co-Payor Class by failing to adhere to the documents and instruments governing the plan, including but not limited to, AB 289. 29 U.S.C. § 1104.

30. Defendant Humana-Insurance engaged in prohibited transactions in violation of its fiduciary duties by dealing with the assets of the plan in its own interest or for its own account. 29 U.S.C. § 1106.

31. Defendant Humana-Insurance engaged in prohibited transactions in violation of its fiduciary duties by acting on behalf of Humana whose interests are adverse to the interests of the plan or the Co-Payor Class. Humana-Insurance was prohibited from even negotiating the co-payment amount with its related entity Humana. 29 U.S.C. § 1106.

32. Defendant Humana-Insurance engaged in prohibited transactions in violation of its fiduciary duties by unlawfully receiving consideration for its own personal account in connection with a transaction involving the assets of the plan. 29 U.S.C. § 1106.

33. It would be wrongful for Humana-Insurance to retain monies, in excess of those it might otherwise have been entitled to, when such monies have been obtained wrongfully and in breach of Humana-Insurance's duties to the Co-Payor Class and agreement with the Co-Payor Class.

34. A constructive trust should be imposed on the Defendants which requires turnover of all monies obtained through the scheme described herein.

35. Plaintiffs should be named the beneficiaries of the constructive trust awarded by this Court.

36. As a result of the Defendants' unlawful and/or inequitable scheme heretofore alleged, Plaintiffs have conferred a monetary benefit upon Defendant Humana-Insurance. Defendant Humana-Insurance appreciated and realized the monetary benefit and accepted and retained the monetary benefit under circumstances such that it would be inequitable for Humana-Insurance to retain the monetary benefit without returning the benefit to the Co-Payor Class. As a result of the scheme, the Defendant Humana-Insurance was unjustly enriched, all to the detriment of the Co-Payor Class.

37. The acts and practices of Humana-Insurance as set forth and described herein are reasonably likely to continue in the future and cause further injury and damage to Plaintiffs unless restrained by order of this Court, and therefore the Co-Payor Class is entitled to a permanent injunction against Humana-Insurance.

38. The Co-Payor Class has been damaged as a result of the breach of ERISA fiduciary duties by Humana-Insurance,

and it is estimated that the approximate actual damages are in excess of $84,520,143.00.

39. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered; Waite, Schneider, Bayless & Chesley Co., L.P.A.; Cummings, Cummings & Dudenhefer; and Gauthier & Murphy to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor. 29 U.S.C. § 1132(g).

SECOND CLAIM FOR RELIEF

(Anti-Trust)

40. Plaintiffs reassert and reallege each and every allegation contained in paragraphs 1 through 39 of the Complaint as though fully set forth at this point.

41. This Premium-Payor class consists of individuals or entities paying all or a portion of the Humana-Insurance premiums during the period 1985 to 1988, including but not limited to employers who made insurance premium payments on behalf of their employees, as well as individual employees who either directly paid insurance premiums on behalf of their dependents, or who did so indirectly by such means as payroll deductions by their employers.

42. Defendant Humana is in the business of owning and operating for-profit acute care health facilities. Humana owns and operates a for-profit acute care health facility named Humana-Sunrise Hospital which provides a full range of hospital services within Clark County, Nevada. Approximately sixty percent (60%) of the gross charges for all patients hospitalized in major for-profit acute care facilities in Clark County, Nevada were billed by Humana-Sunrise Hospital in the relevant time period. This percentage is, and at all times relevant hereto has been, the largest market share of any for profit acute care facility in Clark County, Nevada.

43. At all times relevant hereto, the hospital charges billed by Humana for hospitalization at Humana-Sunrise were anti-competitively high compared to comparable geographic markets. In 1986, the State of Nevada had the highest per patient day billed charges in the United States and Humana-Sunrise had the highest per patient day billed charges in the State of Nevada; i.e., $1,617 per patient day. At all times relevant hereto, the percentage return on investment at Humana-Sunrise was anti-competitively high compared to comparable geographic markets. In 1986, Humana-Sunrise possessed a 37.44% return on investment. At all times relevant hereto, the profit margin of Humana-Sunrise was anti-competitively high compared to comparable geographic markets. In 1986, Humana-Sunrise possessed a profit margin of 36% compared to a national average of 14.4%.

44. In 1984, Humana, through its wholly-owned subsidiary, GROUP HEALTH, began to market and sell group health insurance policies in Clark County, Nevada. Aforesaid policies were sold through organized advertising activities in Clark County, Nevada, by means of newspaper advertisements, radio advertisements and television advertisements. GROUP HEALTH marketed and sold such policies through its wholly-owned subsidiary Humana-Insurance using public advertising and private solicitation. In utilizing the above-described marketing scheme, Humana did so for the primary purpose of maintaining Humana's dominant market share of the gross charges from all patients hospitalized in major for-profit acute care facilities in Clark County, Nevada by maintaining or increasing the number of patients utilizing Humana-Sunrise.

45. Humana and Humana-Insurance controlled the pricing mechanisms for the per diem charges for impatient hospitalization and hospital services billed by Humana and for Humana group health policies. Humana and Humana-Insur-

ance engaged in predatory pricing to give Humana an unlawful competitive advantage by allowing it to maintain, through revenues transmitted to its subsidiary by secret discounts, an anti-competitively high profit by maintaining or increasing the number of patients and in addition, by providing Humana-Insurance with a significantly lower per diem charge. As a result of aforesaid unlawful efforts to maintain or increase its market share and also as a result of aforesaid predatory pricing, Humana successfully and wilfully maintained its overwhelming percentage of the gross charges for all patients hospitalized in major for-profit acute care facilities in Clark County, Nevada.

46. The insurance agreement sold and marketed by Humana-Insurance through public advertising and private solicitation required its insureds to pay all expenses up to the designated deductible amount, and twenty percent (20%) of all expenses beyond the deductible; Humana-Insurance was required to pay the remaining eighty percent (80%) beyond the deductible.

47. Humana (Humana-Sunrise) and Humana-Insurance entered into a secret agreement in 1984 pursuant to which Humana-Insurance would pay Humana a discounted amount for the portion of the per diem hospital charges for which it was responsible. No comparable discount was provided to other group health insurers. No comparable discount was provided on that portion of the charges paid by the insureds. Humana and Humana-Insurance agreed to keep this agreement secret from the Premium-Payor Class, the general public and state agencies.

48. Since at least 1984, and to and including the date of the filing of this Complaint, Humana and Humana-Insurance have violated Section 2 of the Sherman Act (15 U.S.C. § 2) by monopolizing or attempting to monopolize the provision of major for-profit acute care facilities in Clark County, Nevada.

49. In furtherance of the aforesaid monopolization and attempt to monopolize, Defendant Humana and Humana-Insurance have developed a mutually supportive system to engage in specific unlawful acts and practices for the express purpose of maintaining anti-competitively high hospital profits in the provision of for-profit acute care hospital services in Clark County, Nevada or for the express purpose of establishing a dominant market share for the provision of Group Health Care Policy insurance, the latter which market share was used as a mechanism for maintaining or increasing the patients for acute hospital care services at Humana-Sunrise. Aforesaid specific unlawful acts and practices include, but are not limited to the following:

A. Promoting the use of Humana-Sunrise Hospital's services instead of other hospitals through Humana Care Plus insurance policies offered by Humana-Insurance by requiring extensive penalties for insureds who failed to use Humana-Sunrise Hospital. These penalties include, but are not limited to the following:

1. Requiring a different and punitive deductible for obtaining services from non-Humana for-profit acute care hospitals;

2. Requiring a different and punitive co-payment for obtaining services from non-Humana for-profit acute care hospitals;

3. Applying a different standard of review when evaluating and paying claims from non-Humana for-profit acute care hospitals. Humana-Insurance systematically denied certain items of non-Humana hospitalization claims prolonged the time of payment for non-Humana hospitalization claims and prolonged the appeal process time of non-Humana hospitalization claims.

B. Humana engaged in a pattern of predatory pricing by offering Humana-Insurance an unreasonable discount not extended to other group health care insurance entities in the Clark County, Nevada area and not extended to persons or entities paying co-payments. This unlawful behavior bestowed upon Humana an unlawful anti-competitive advantage by allowing it to collect co-payments from patients and non-Humana insurance group health insurers based on the purported per diem. At the same time, this unlawful behavior bestowed a further unlawful anti-competitive advantage upon Humana by allowing it to limit its purported profits by the discounted per diem extended to Humana-Insurance, thereby evading the ceiling upon Humana's profits which would have been imposed by cost-containment legislation. This unlawful behavior also bestowed an unlawful anti-competitive advantage upon Humana-Insurance by charging it less per diem than other group health insurers were charged by Humana;

C. Humana's wholly owned subsidiary Humana-Insurance offered premium rates for group health insurance policies that are anti-competitively high compared to premium rates in comparable geographic markets because of the anti-competitively high charges for hospital services in Clark County, Nevada, compared to comparable geographic markets;

D. Humana's wholly-owned subsidiary Humana-Insurance offered premium rates for group health insurance policies above reasonable actuarial practices would have determined based an the predatory discounted per diem charge that it received but which was not extended to other group health insurers or co-payors; and

E. While the premium rates for health insurance policies offered by Humana-Insurance were anti-competitively high compared to premium rates in comparable geographic markets, Humana-Insurance initially engaged in predatory pricing within the Clark County market itself by attempting to under-cut the charges by other group health insurers in the Clark County market. The express purpose of this initial predatory pricing was to obtain market share for the Humana group health policy. After successfully acquiring market share through the initial predatory pricing, Humana-Insurance then raised its premiums.

50. By means of the acts hereinabove described, Humana and Humana-Insurance have acquired or maintained or attempted to acquire and maintain a monopoly on for-profit acute care hospital services in Clark County, Nevada and Humana and Humana Health Insurance have attempted to acquire and preserve a dominant market share for the provision of Group Health Care Policy insurance in the Clark County, Nevada area, the latter which dominant market share was used as a mechanism for maintaining or increasing the patients for acute hospital care services at Humana-Sunrise.

51. As a direct and proximate result of the anti-competitive actions hereinabove recited, and as intended by Defendant Humana and Humana-Insurance, the Anti-Trust Class has sustained damages in that it was required to pay anti-competitively high premiums for group health care policies in the Clark County geographic market compared to premiums charged for comparable group health policies in comparable geographic markets and in that it was required to pay anti-competitively high co-payments based on the anti-competitively high hospital charges billed by Humana.

52. It is estimated that the approximate actual damages of the Anti-Trust Class are in excess of $181,034,570.00, the principal of which is subject to trebling.

53. The anti-competitive acts and practices of Humana and Humana-Insurance as set forth and described herein are reasonably likely to continue in the future and to cause further injury and damage to Plaintiffs unless restrained by order of this Court.

54. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered; Waite, Schneider, Bayless & Chesley Co., L.P.A.; Cummings, Cummings & Dudenhefer; and Gauthier & Murphy to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor.

THIRD CLAIM FOR RELIEF

(18 U.S.C. §§ 1961-1968)

55. Plaintiffs reassert and reallege each and every obligation contained in paragraphs 1 through 54 of the Amended Complaint as though fully set fourth at this point.

56. As part of a scheme to defraud Plaintiffs by charging Plaintiffs a different per diem per patient day on their co-payments, Humana and Humana-Insurance entered into a secret agreement (the "Agreement"). Pursuant to the Agreement, Humana-Insurance agreed to pay Sunrise Hospital a discounted amount for that portion of the hospital charges for which it was responsible. The portion of the charges paid by others, however, was not discounted but was still based on the usual and customary rate.

57. Premiums were not reduced by Humana-Insurance in the amount discounted. It was part of the scheme to defraud that Humana and Humana-Insurance used false and fraudulent pretenses, representations and promises calculated to deceive persons of ordinary prudence and due care and make material nondisclosures and concealment of fact and information important to the insureds (including but not limited

to the existence of the secret agreement and the fact that Humana was billing Humana-Insurance at a different per diem) all so as to unlawfully, intentionally and wilfully, and with the intent to defraud, that is, knowingly and with specific intent to deceive in order to cause financial gain to themselves, procure secret profits to the use and benefit of themselves and others and to the detriment of the insureds consisting of the named Plaintiffs, as representatives of a class pursuant to Fed.R.Civ-Pro. Rule 23.

58. The scheme to defraud evolved over time a pattern of illegal activity that inflicted discrete harms on the insureds and others. The insureds, as victims of the unlawful patterns of illegal activity, also suffered discrete losses as a result of these activities. The multifarious illegal activities through which the broad objectives of Humana and Humana-Insurance were carried out consisted of a complex pattern of individual transactions and group transactions. In carrying out the scheme to defraud, Defendants, Humana and Humana-Insurance engaged, *inter alia,* in conduct in violation of federal laws, to wit: 18 U.S.C. Section 1341 and 18 U.S.C. Section 1343, as stated below:

(A) *18 U.S.C. Section 1341.* As part of the false and fraudulent scheme to defraud, Defendant Humana and/or Defendant Humana-Insurance, caused to be sent through the United States mail explanations of benefits, patient account statements, itemized statements, demand letters and other correspondence in order to collect co-payments from insureds for hospital charges as Sunrise Hospital. Defendant Humana and/or Defendant Humana-Insurance, did not inform the insureds that Humana and Humana-Insurance had entered into an agreement specifically providing for the insurance company to pay the hospital based on a discounted rate while the insureds were to pay based on the usual and customary rate. This material nondisclosure and concealment of facts and information from the insureds was intentionally

and knowingly conceived in order to deceive the insured and obtain financial gain. This use of the United States mail in furtherance of the false and fraudulent scheme violates 18 U.S.C. Section 1341.

(B) *18 U.S.C. Section 1343.* As part of the false and fraudulent scheme to defraud, Defendant Humana and/or Defendant Humana-Insurance transmitted or caused to be transmitted in interstate commerce wire, radio, and television transmissions, including without limitation the following:

(1) Defendants sent, or caused to be sent, through interstate radio and television transmissions, advertisements promoting the Humana group health policy. Those radio and television transmissions were broadcast from locations in Nevada across state borders to persons located in Arizona and/or Utah. In those transmissions Defendant Humana and/or Defendant Humana-Insurance did not inform the insureds that Humana and Humana-Insurance entered into an agreement specifically providing for the insurance company to pay the hospital based on a discounted rate while the insureds were to pay based on the usual and customary rate. This material nondisclosure and concealment of facts and information from the insureds was intentionally and knowingly conceived in order to deceive the insureds and obtain financial gain.

(2) Defendants used the interstate telephone lines to explain or discuss billings in order to collect co-payments from insureds for hospital charges incurred at Sunrise Hospital. Defendants maintained offices both in Las Vegas, Nevada and in Louisville, Kentucky. Defendants engaged in telephone conversations from their Nevada offices with Plaintiffs located in other states, including without limitation Arizona, California,

and Utah, and from their Kentucky offices with Plaintiffs located in other states, including without limitation Arizona, California, Nevada, and Utah. In those telephone conversations Defendant Humana and/or Defendant Humana-Insurance did not inform the insureds that Humana and Humana-Insurance entered into an agreement specifically providing for the insurance company to pay the hospital based on a discounted rate while the insureds were to pay based on the usual and customary rate. This material nondisclosure and concealment of facts and information from the insureds was intentionally and knowingly conceived by Defendants in order to deceive the insureds and obtain financial gain.

(3) On or about December 1, 1987, Defendants established a Louisville Claims Center in Louisville, Kentucky and a toll-free telephone line to that office for the specific purpose of handling claims from corporate Plaintiffs located in Nevada (Exhibit A). Defendants engaged in telephone conversations from their Kentucky offices with corporate Plaintiffs located in Nevada. In those conversations Defendant Humana and/or Defendant Humana-Insurance did not inform the insureds that Humana and Humana-Insurance entered into an agreement specifically providing for the insurance company to pay the hospital based on a discounted rate while the insureds were to pay based on the usual and customary rate. This material nondisclosure and concealment of facts and information from the insureds was intentionally and knowingly conceived by Defendants in order to deceive the insureds and obtain financial gain.

(4) Defendants engaged in telephone conversations from their offices in Louisville, Kentucky with persons in Nevada in the offices of the government of the State of Nevada for the purpose of executing Defendants' scheme to defraud. For example, on May 2, 1989, John

Andris, in-house counsel for Defendants, placed a telephone call to Herschell Dunham of the Nevada Insurance Division, concerning the merger of Humana-Insurance with Humana, Inc. and documents requested by the Insurance Division relating to the Division's examination of Humana-Insurance (Exhibit B). These telephone conversations were in support of the scheme to defraud.

(5) Plaintiffs are informed and believe and thereupon allege that Humana, Inc. and/or Humana-Insurance transferred millions of dollars by wire transfer from Nevada to other states and from other states to Nevada for the purpose of executing Defendants scheme to defraud. For example, on or about March 2, 1984, Humana, Inc. ordered $1,501,355,63 transferred by wire from Louisville, Kentucky to First Interstate Bank in Reno, Nevada for the purchase of a Treasury Bill to be held at the bank in an account maintained in the name of Humana-Insurance (Exhibit C). This interstate transfer of funds was in support of the scheme to defraud.

This use of interstate wire transmissions in furtherance of the false and fraudulent scheme violates 18 U.S.C. § 1343.

59. The Plaintiffs and the members of the designated class which they represent are each a "person" within the meaning of 18 U.S.C. § 1961(3) and § 1964(c).

60. Defendant Humana is a "person" within the meaning of 18 U.S.C. § 1963(3) and § 1964(c). Defendant Humana-Insurance is an "enterprise" within the meaning of 18 U.S.C. § 1961(4) and § 1962(c), which enterprise was engaged in and the activities of which affected interstate commerce during the relevant times. Defendant Humana was associated with an enterprise, that is, Humana-Insurance, and did conduct or participate directly or indirectly, in the

conduct of the affairs of Humana-Insurance through a pattern of activity within the meaning of 18 U.S.C. §§ 1961 (1)(B), 1961(5) and 1962(c), to-wit:

(a) Multiple instances of violations of 18 U.S.C. § 1341;

(b) Multiple instances of violations of 18 U.S.C. § 1343.

61. Humana and Humana-Insurance are an association-in-fact that constitutes an "enterprise" within the meaning of 19 U.S.C. § 1961(4) and § 1962(c), which enterprise was engaged in and the activities of which affected interstate commerce during the relevant times.

62. By reason of the violations of 18 U.S.C. § 1962(c) committed by Defendants Humana, it is estimated that the approximate actual damages of the RICO class are in excess of $181,034,570.00, the principal of which is subject to trebling.

63. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered; Waite, Schneider, Bayless & Chesley Co., L.P.A.; Cummings, Cummings & Dudenhefer; and Gauthier & Murphy to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor.

WHEREFORE, Plaintiffs pray for judgment against Defendants, jointly and/or severally, where applicable in each claim for relief as follows:

1. An amount in excess of $84,520,143.00 based upon the ERISA violations by Humana-Insurance on the First Claim for Relief.

2. A constructive trust be imposed in the amount of all monies received as a result of the scheme, with Plaintiffs to be named as the beneficiaries of the trust on the First Claim for Relief.

3. For declaratory judgment and permanent injunction establishing the rights and duties between the parties and for judgment requiring Humana-Insurance to cease and desist from the wrongful conduct described in the First Claim for Relief.

4. For general, special, and compensatory damages in an amount in excess of $181,034,570.00, on the Second Claim for Relief, which damages are subject to trebling (excluding interest) for a total amount in excess of $421,426,569.00.

5. For declaratory judgment and permanent injunction requiring Defendant to cease and desist the wrongful conduct described in the Second Claim for Relief.

6. For general, special, compensating damages in an amount in excess of $181,034,570.00 on the Third Claim for Relief, which damages are subject to trebling (excluding interest) for a total amount in excess of $421,426,569.00.

7. For costs of suit and fees incurred herein.

8. For such further and other relief as the Court deems just and equitable.

DATED this 12th day of August, 1991.

JONES, JONES, CLOSE
& BROWN, CHARTERED

By /s/ J. Randall Jones
J. RANDALL JONES, ESQ.
WILL KEMP, ESQ.
300 South Fourth Street
Las Vegas, Nevada 89101

WAITE, SCHNEIDER, BAYLESS
& CHESLEY CO., L.P.A.

By /s/ J. Randall Jones /for
STANLEY M. CHESLEY, ESQ.
1515 Central Trust Tower
Fourth and Vine Streets
Cincinnati, Ohio 45202

CUMMINGS, CUMMINGS & DUDENHEFER

By /s/ J. Randall Jones /for
JOHN L. CUMMINGS III, ESQ.
416 Gravier Street
New Orleans, LA 70130

GAUTHIER & MURPHY

By /s/ J. Randall Jones /for
WENDELL GAUTHIER, ESQ.
3500 North Hullen Street
Metairie, LA 70002

ATTORNEY FOR PLAINTIFFS

Plaintiffs demand a trial by jury on all issues so triable.

JONES, JONES, CLOSE
& BROWN, CHARTERED

By /s/ J. Randall Jones
J. RANDALL JONES, ESQ.
WILL KEMP, ESQ.
300 South Fourth Street
Suite 700
Las Vegas, Nevada 89101

CERTIFICATE OF MAILING

I hereby certify that on the 12th day of August, 1991, the foregoing Second Amended Complaint and Jury Demand was served on the parties by mailing a copy thereof, first class mail, postage prepaid, to:

Louis E. Garfinkel, Esq.
LIONEL SAWYER & COLLINS
300 South Fourth Street
Suite 1600
Las Vegas, Nevada 89101

Mark J. Biros, Esq.
CASSON, HARKINS & LAPALLO
1233 20th Street, N.W., #800
Washington, D.C. 10036

/s/ Janet L. Slone
An employee of JONES, JONES,
CLOSE & BROWN, CHARTERED

[Letterhead of Humana Health Care Plans, Las Vegas, Nevada]

November 13, 1987

Mr. Robert Evans
Supervisor Life and Health
Department of Commerce
Insurance Division
201 South Fall Street
Carson City, Nevada 89710

Re: Transfer of claims processing and payment from Mutual Administrators, Inc. to Humana Corporate Claims System, Louisville, Kentucky.

Dear Bob,

The primary purpose for the above transfer is to better serve the consumer by providing them the claims, utilization, and trend reports on a regular basis. By providing these reports, it will enable the consumer to better manage health care costs and provide a review of when employees and dependents are using health care services. These kinds of reports currently are not able to be generated on a regular basis through Mutual Administrators, Inc. Also, this will enable Humana Health Insurance of Nevada, Inc. to better comply with the recent proposed Legislation in reporting data on health costs to the Department. The following is an outline of notification and implementation:

1. Notification:
   (a) Effective data of termination of contract is December 1, 1987.
   (b) Mutual Administrators, Inc. will be notified in person with letter on November 19, 1987.
   (c) All accounts will be notified by mail (letter) November 19, 1987 by Humana Health Insurance of Nevada, Inc.

(d) All brokers will be notified by mail (letter) November 19, 1987 by Humana Health Insurance of Nevada, Inc.

(e) All providers will be notified by mail (letter) November 19, 1987 by Humana Health Insurance of Nevada, Inc.

(f) Legal council has approved termination.

2. Responsibilities:

(a) Mutual Administrators, Inc.

(1) Through November 30, 1987, Mutual Administrators, Inc. will be responsible for all claims incurred and reported.*

(2) Mutual Administrators, Inc. will be responsible for the runout.*

(b) Humana Health Insurance of Nevada, Inc.

(1) Currently Humana, in Las Vegas, has five customer service representatives, four trained and one to be trained by December 1, 1987.

(2) Currently ten terminals with inquiry capabilities with wiring and equipment for an additional twelve stations, if necessary.

(3) Additional personnel to be added as needed.

(4) Twenty-four hour hot line service to Las Vegas office.

(5) Seventeen lines available for consumer inquiries.

(6) Additional 2400 square foot in current building for expansion.

(7) An 800 number to Las Vegas office for customer service outside of Clark County.

(8) Account will be set up at FIB in Nevada for claims payments.

(c) Humana Corporate Claims - Louisville, Kentucky:

* If Mutual Administrators, Inc. refuses to accomodate, Humana is prepared to assume the responsibility.

(1) Adjudicate and pay claims for Nevada.

(2) Produce cards - cards have been ordered (temporary cards for December 1, 1987 and new permanent cards by January 1, 1988.

(3) Plans loaded and tested successfully in Corporate system for implementation December 1, 1987 or earlier if necessary.

(4) An 800 number to Corporate customer service in addition to local customer service lines.

(5) Provide regular reports (see attached).

(6) Two Corporate claims managers will be in Las Vegas the week of November 9, 1987 for claims instruction and coordination.

b, if any other information is needed, please give me a call.

Sincerely,

/s/ John R. Egermayer
John R. Egermayer
Executive Director

JRE:dw

cc: Roger Collins
Larry Cash
Judy Zelinski
Joyce Anderson
Bruce McClure
Jerry McClellan
Joe Lawrence

[Message Form—Tops Form 3002P]

IMPORTANT MESSAGE

FOR Herschell

DATE 5-2 TIME 11:20 A.M.

M John Andris

OF Humana (law Dept)

PHONE 502-580-3717

TELEPHONED ✓ PLEASE CALL ✓

MESSAGE Merger &
documents you
asked for regarding
exam

SIGNED SKK

[Letterhead of First Interstate Bank, Reno, Nevada]

March 9, 1984

Mr. David Reinhardt
Investment Management Department
Humana, Inc.
P. O. Box 1438
Louisville, Kentucky 40201

Dear Mr. Reinhardt:

Enclosed is the confirmation statement for the Treasury Bill purchased on March 2, 1984. Although the statement shows principal of $1,501,300.00, please let this letter confirm receipt from you for $1,501,355.63 by wire on March 2.

For your information, we have reserved a corporate demand account number 002-0011288 for Humana Health Insurance of Nevada, Inc. To complete required documentation, kindly fill in the items checked on the enclosed signature cards/ corporate resolution form and the taxpayer identification form, and return these at your earliest convenience.

We appreciate your selecting First Interstate Bank of Nevada, N.A. for your banking needs.

Sincerely,

/s/ Marvin M. Mann

MMM:aa

Enclosures

[Form AC-250T (0983), First Interstate Bank, Reno, NV]

Confirmation and Statement

Order No. 0011—T

We confirm according to the transaction code below and the terms stated hereon and the reverse side hereof. If this confirmation is not in all respects in accordance with your understanding, please notify us immediately.

Account Number (BLANK) Trade Date 3-1-84
Settlement Date 3-2-84 Security Number/Cusip (BLANK)

Humana Health Insurance
of Nevada, Inc.
C/O Marvin Mann

PRINCIPAL $1,501,350.00

TOTAL AMOUNT DUE $1,501,350.00

Transaction X Sold Type I Tran Code 2
Trader/Salesman 2 Price 95,3238 Rate 9.30 Disc

Par Value $1,575,000.00 Yield 9.89

Description U.S. Treasury Bills Due 8-30-84

Payment and Delivery Instructions: Hold in Safekeeping

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

Case No. CV-S-89-249-PMP

MARY FORSYTH, et al.

Plaintiffs,

vs.

HUMANA, INC., et al.

Defendants.

STATE OF OHIO)
) SS:
COUNTY OF HAMILTON)

AFFIDAVIT OF BARON T. YOUN

I, Baron T. Youn, being duly sworn, depose and state as follows:

1. I am a computer data consultant retained by Plaintiffs' counsel to examine the data submitted by Humana Inc. (Humana) as well as the assumptions upon which the damage calculations were based. The set of data files I reviewed was to be the exact same set that Humana used to calculate their financial compensation liability in this case. I have also reviewed the deposition and affidavit testimony of Bruce McClure and Joseph Shutts.

2. The data I was instructed to review was supplied on magnetic tape and supplied in the EBCIDIC format. This data was actually a series of reports that were run and the output data was directed to a data file instead of being directed to a printer. This re-direction to a data file was necessary because the reports contain over 220,000 transactions. The EBCIDIC encoded data on the magnetic tape was converted to ASCII format and transferred to media that is capable of being read on an IBM PC compatible personal

computer. This conversion process uses was performed by the Shafstall Corp. located in Indianapolis, Indiana and specialists in data format conversion. The conversion does not alter any values of the data, only the format.

3. Upon careful study and review of the data submitted by Humana, I have found several errors in their calculations. For example, on page one of the report labeled "HUMANA DIFFERENCE FOR NEVADA MEMBERS, DETAIL REPORT FOR THE CALENDAR YEAR ENDING ON 12/31/85", I have found two separate transactions that are in error out of the twelve transactions listed on that page. If this error rate is multiplied across the 220,000 plus transactions, any calculations using this data set will be flawed. Since this data set is alleged to be the same data set Humana used to figure their liability, their resultant sum they arrived at using this data set must be disregarded because of the errors contained in the original data set.

I declare under penalty of perjury that the forgoing is true and correct to the best of my knowledge, information and belief.

/s/ Baron T. Youn
Baron T. Youn

Subscribed and sworn to before me by Baron T. Youn this 17th day of February, 1994, to be his free act and deed.

My Commission expires:
July 30, 1997

/s/ Amy L. Kindell
Notary of Public

[stamp—AMY L. KINDELL/Notary Public, State of Ohio/
My Commission Expires July 30, 1997]

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE No. CV-S-89-249 PMP (LRL)

MARIETTA CADE, *et al.*,

Plaintiffs

v.

HUMANA INC., *et al.*,

Defendants

COMMONWEALTH OF KENTUCKY)
) ss:
COUNTY OF JEFFERSON)

AFFIDAVIT OF BRUCE K. McCLURE

I, Bruce K. McClure, being duly sworn, depose and state as follows:

1. I am employed by Humana Inc. ("Humana") as Director of Claims - Finance and Administration.

2. I have been employed by Humana since March, 1983.

3. I am responsible for directing and managing Humana's claims processing systems for Humana's health insurance and health maintenance organization subsidiaries including Humana Health Insurance of Nevada, Inc. ("Humana Insurance").

4. I supervised an analysis of all claims submitted by persons insured by Humana Insurance during 1984-1988, inclusive, who had a coinsurance obligation to Humana Hospital-Sunrise under their health insurance policies. Part of the purpose of this analysis was to identify for each year in question the total dollar difference between the insureds'

coinsurance obligations when their coinsurance was calculated on the basis of the hospital's charges versus the discounted amount of the hospital's charges. In order to determine the difference in the coinsurance obligations, I reviewed pages 18-21 of the July 21, 1993 Memorandum Decision and Order (the "Order") of the Court in this matter and applied the formula set out in the Order to the claims described above. The total amount of out-of-pocket obligations of these insureds in excess of what they would have owed if their coinsurance was on the discounted amount (taking into effect in each case their personal expense limitation) for the years 1984-1988 was $1,623,312. The table below sets out the amount for each year in question:

Year	Reduction in Co-Insurance Obligation If Co-Insurance Based on Discounted Amount
1984	$ 24,103
1985	420,658
1986	604,948
1987	410,033
1988	163,570
TOTAL	$1,623,312

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge, information and belief.

/s/ Bruce K. McClure
Bruce K. McClure

Subscribed and sworn to before me by Bruce K. McClure this 9th day of November, 1993, to be his free act and deed.

My Commission expires: September 20, 1997

/s/ [*signature illegible*]
NOTARY PUBLIC,
STATE AT LARGE

AFFIDAVIT OF EDWARD CUPIT, CPA

STATE OF NEVADA)
) ss.
COUNTY OF CLARK)

EDWARD CUPIT, being first duly sworn, deposes and says:

1. I, Edward Cupit, am a certified public accountant, duly authorized to practice in the state of Nevada.

2. I am a partner in the accounting firm of Cupit, Milligan & Ogden, which firm is located at 1695 Meadow Wood Lane, Suite 100, Reno, Nevada 89502.

3. This affidavit is offered on behalf of Plaintiffs in the matter of *Forsyth v. Humana,* CV-S-89-249-PMP (LRL), in reference to Plaintiffs' Motion for Reconsideration.

4. I have examined records indicating the discounts that Humana Hospital granted to numerous insurance companies and self-insured employers (together "insurers") during the period from 1986 through 1988. In my professional opinion, calculating the difference between the average of those discounts and the discounts that Humana Hospital granted Humana Insurance during the same period represents a reasonable alternative method of determining the "profit" that Humana Insurance derived as a direct consequence of its discount arrangement with Humana Hospital.

5. I have calculated that amount as follows:

a. During the year ended August, 1986, Humana Hospital's average discount to all insurers other than Humana Insurance was 38.2%. During the year ended August, 1987, that average discount was 44.9%. During the year ended August, 1988, that average discount was 44.7%. I do not have records indicating the average discounts before the year ended August, 1986, or after the year ended August, 1988.

b. During the years ended in August, 1986, August, 1987, and August, 1988, the discount that Humana Hospital granted to Humana Insurance was 89.1% The difference between that discount and the average discount that Humana Hospital granted to other insurers during those years (43.4%), was 45.7% Humana Hospital transferred $44,382,000 to Humana Insurance in the form of discounts for this period. Applying 45.7% to those discounts yields a total of $20,282,574.

d. The total of $20,282,574 represents a reasonable calculation of the "profit" that Humana Insurance derived as a direct consequence of its discount arrangement with Humana Hospital during the years indicated, not including interest.

DATED this 10th day of November, 1993.

/s/ Edward Cupit
EDWARD CUPIT

State of California)
County of _____)

On Nov. 10, 1993 before me, Amy Jordan personally appeared Edward Cupit personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s) or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

Signature /s/ Amy Jordan

[stamp—OFFICIAL SEAL/AMY JORDAN/NOTARY PUBLIC--
CALIFORNIA/Principal Office in MARIN County/
My Commission Expires July 18, 1994]

SUPPLEMENTAL REPORT OF EDWARD CUPIT

I. Materials Reviewed:

1. Plaintiffs' Complaint filed 3/29/85
2. Plaintiffs' Amended Complaint filed 10/27/89
3. Plaintiffs' Second Amended Complaint filed 8/12/91
4. Order of the Honorable Philip M. Pro, dated July 8, 1991
5. Nevada Quarterly financial statements of Sunrise Hospital for the years 1985 - 1989
6. Quarterly financial statements of Humana Insurance for the years 1985 - 1988 to the Nevada Department of Insurance
7. Annual statements for Humana Insurance filed with the Nevada Insurance Department for the years 1985 - 1988
8. Annual Published Financial Statements for 1985 - 1988
9. Humana, Inc. Medicare Home Office Reports from Blue Cross of Kentucky and Aetna
10. 10/14/86 Report of Examination prepared by Insurance Division of Humana Health Insurance of Nevada
11. 9/30/88 Report of Examination prepared by Insurance Division of Humana Health Insurance of Nevada
12. 7/21/89 Report of Examination to Determine Compliance with Assembly Bill 289 and 278 of Humana Health Insurance of Nevada
13. 8/31/89 Proposed amended Report of Examination to Determine Compliance with Assembly Bill 289
14. 10/18/89 amended 3/21/1990 Examination of Humana Health Insurance of Nevada

15. 3/3/89 Partial Transcript of proceedings of Senate Committee on Commerce and Labor Meeting
16. Nevada Division of Health Resources and Cost Review, Nevada Major Hospitals: 1986 Information
17. Report of Nevada Average Hospital Charges for the period 1/1/87 through 6/30/87 as prepared by Nevada's Division of Health Resources and Cost Review
18. 5/15/89 report of the Commissioner of Insurance re: Analysis of AB 289
19. Humana Health Insurance of Nevada, Inc. Actuarial Memorandum for the year ending 12/31/87 by David W. Wille, FSA, MAAA, Chief Actuary
20. 6/15/88 memo to Gail Knopf, Rocky Lubbers from Penny Nader re: Monthly Mutual Tapes
21. 1/26/89 letter to Teresa Rankin from David Wille re: Premium Rate Formula For Humana Health Insurance Company of Nevada
22. 2/3/89 letter from John Egermayer to Teresa Rankin re: Response to examination by the State of Nevada completed 9/30/88 and accompanying cover dated 1/3/89
23. 3/31/89 memo to Larry Cash from David Wille re: Best Auto Glass
24. 4/10/89 memo to Jim McCready from David Wille re: Nevada Rate Formula
25. 5/2/89 letter to David Gates from Larry Cash re: Actuarial Examination Review
26. Comparative Analysis of Hospital Data for the Years Ended June 30, 1987 and 1988
27. Report reflecting patient days, Charges and Discounts for HMO/PPO programs for August 1988 vs. 1989

28. Report reflecting patient days, charges and discounts for HMO/PPO programs for August 1987 vs. 1988
29. Discount Analysis for YTD August FY 86 for Humana Hospital Sunrise
30. Discount Analysis YTD 8/88
31. Schedule reflecting Humana Care Plus revenues and discounts at Humana Hospital Sunrise for the period 7/88 to 12/88
32. Testimony of Samuel Hazen during trial of Humana vs. Hemmeter
33. 9/16/87 Memo from Rob Leo to Steve Monaghan re: Methodology for Base Year Net Revenue for 7/1/86 to 6/30/87
34. 5/22/86 Memo from Mike O'Brien to Gary Metcalf re: Analysis of Discount Programs - April, 1986 including attached reports re: same
35. 8/15/85 report of audit of Mutual Administrators conducted by Humana Health Insurance Company of Nevada
36. 1985 Nevada Hospital Financial Annual Report for Humana Hospital Sunrise and MOB's
37. 2/1/85 Memo to Gary Hill from Jerry Anderson re: Nevada Hospital Financial Quarterly Report
38. 6/26/85 letter from Roger Collins to Teresa Rankin re: clarification of alleged overcharging of Champus
39. 7/15/85 letter from Roger Collins to Department of Human Resources enclosing response to additional questions regarding CON application submitted for Humana Hospital Sunrise for the purchase of a lithotriptor

40. 11/2/87 Memo to Don Stewart from Rob Leo re: private pay business increase with attached graph of private pay trends
41. 11/11/87 Memo from Rob Leo to Donald Stewart re: Patient Mix Trend including handwritten ledger
42. 2/16/88 letter from Larry Howard of HPN to Rob Leo re: proposal of 2/4/88
43. 3/3/88 Memo from Rob Leo to Gary Hill re: HPN Proposal with attached analysis
44. 5/3/88 Memo from Rob Leo to James Bohanon re: Salient Points of HPN Contract
45. 9/21/87 letter from R. G. Shannon Administrators to Rob Leo re: resolution of problems
46. 7/16/87 Memo from Rob Leo to Gary Hill re: Legislative Update
47. 9/16/87 Memo from Rob Leo to Steve Monaghan re: Methodology for Base Year Net Revenue for the period 7/1/86 to 6/30/87
48. 10/13/87 Memo from Rob Leo to Donald Stewart re: Impact of AB 289 on Humana Hospital Sunrise
49. 9/15/87 Memo from Rob Leo to Russ York re: Impact of AB 289 on Humana Hospital Sunrise
50. 1/18/88 Memo from Sam Hazen to Don Stewart re: Ab-289 Analysis
51. 1/4/88 Memo to Gary Hill from Rob Leo re: Humana Care Plus Discount re: recommendation that Humana Insurance reimburse Humana Hospital Sunrise $600.00 per diem for all Humana Insurance patients
52. 10/27/87 Memo to Donald Stewart from Rob Leo re: AB 289 Discussions with Scott Mayne

53. Comparison of AB 289 Revenue Reduction for Non-Medicare/Medicaid for Valley Hospital, Humana Hospital Sunrise and Desert Springs Hospital
54. Business Plan Analysis FY 85-FY 89 - Board of Directors Meeting 7/12/84
55. Master Policy HCP-84-NV-1
56. Policy GP-1000
57. Hospital Participation Agreement between Sunrise and Humana Insurance
58. Business Plan Analysis FY88 - FY90 - Board of Directors' Meeting 9/10/87
59. 10/13/87 Memo to Donald Stewart from Robert Leo re: Impact of AB 289 on HHS
60. 9/16/87 Memo to Steve Monaghan from Rob Leo Re: Methodology for Base Year Net Revenue July 1, 1986 to June 30, 1987
61. 7/12/88 Memo to Larry Cash from Beth Grice Re: Valley Hospital Reserve Statement
62. Analysis of Department of Insurance Complaint Against Humana
63. 6/17/87 Letter to Gregory J. Barlow from Dennis Kennedy re: Humana Subpoenas
64. Status Report from Bear Stearns for Humana, Inc.
65. Industry Report from Morgan Securities dated 12/12/86
66. Hospital Management & Services Progress Report from Morgan Stanley, dated 11/25/86
67. 1986 Annual Report for Humana, Inc.
68. 7/12/88 Memo from Beth Grice to Larry Cash

69. Analysis of Department of Insurance Complaint Against Humana

70. 4/30/87 Memo to David Jones from George Atkins re: Nevada Legislation

71. Humana Inc. Financial Analysis (Profitability of Group Health Division)

72. Financial Analysis - Humana, Inc. (Geographic)

73. Financial Analysis - Humana, Inc. - Income Statements for Selected Years 1976 -1985

74. Hospital Data, 1976 -1985

75. Explanation of Benefits for Helen Snelius Staves

76. 4/22/85 Memo from Larry Cash to Market Offices Sales & Operations Managers re: Financial Information with attached reports reflecting Budget Income Statement Summary (March, 1985), Group Health Division - Inpatient Utilization Report for May, 1985, Report reflecting Groups and Subscribers for Current Period, Fiscal 1985 year to date and Cumulative from Market Opening, Summary of Claims Analysis as of 10/84

77. 11/29/84 Memo from Larry Cash to Carl Pollard re: Humana Hospital Utilization

78. 12/7/84 Memo from Larry Cash to Carl Pollard re: Humana Hospital Utilization

79. 12/10/84 Memo to Market Operations Managers from Larry Cash re: Humana Hospital Utilization

80. 7/16/85 Memo to Brenda Bryant from Gloria Luber re: Printed Marketing Material Impact for companies with 5 - 9 employees

81. Certificate dated 8/22/85 authorizing a capital contribution in the amount of $1,500,000.00 from Group

Health Insurance, Inc. to Commercial State Life Insurance Company

82. 10/9/85 Memo to Regional Operations and Sales Directors from Diane Millett re: Financial Reports.

83. 10/22/85 Memo from John Reilly, Rich Robinson to Larry Cash re: Las Vegas Revenue understatement of June, 1985 through October, 1985 billings for the Police Protection Association

84. 3/17/86 Memo to Larry Cash and Wes Burbank from Robert J. Lubbers re: Trip Report - Mutual Administrators' Claims Audit - Nevada Markets

85. Plan Summary - out of pocket costs as of 2/1/86 for Humana Inc and Humana Health Insurance of Nevada, Inc.

86. 4/7/86 letter from Larry Cash to Department of Insurance re: Quotes, Rates - Small Group Product

87. 5/21/86 letter from Robert Lubbers to Michael Manges re: Calculation of Per Diem and Percentage of Charges, Participating Hospital Payments

88. 4/16/86 Memo to Betty Chowning from Joe Lawrence re: Incorrect payment of Non-Humana Participating Hospitals in the Nevada Market with attached back up documentation

89. 6/13/86 Minutes of Special Meeting of Board of Directors of Group Health Insurance, Inc. authorizing a $16,000,000 capital contribution from Humana, Inc. to Group Health Insurance, Inc.

90. 6/16/86 Memo from Robert J. Lubbers to Joe Lawrence re: Nevada Market Reserve Calculation

91. 7/17/86 letter from Michael Manges to Frank Guisti attaching examples of how claims for Humana Participating Providers are being paid

92. 9/25/86 Minutes of a Special Meeting of the Board of Directors of Group Health Insurance, Inc. acknowledging receipt of a $51,498,979.88 capital contribution from Humana, Inc.

93. 12/9/86 Minutes of a Special Meeting of the Board of Directors of Group Health Insurance, Inc. acknowledging receipt of a $57,000,000 capital contribution from Humana, Inc.

94. Documentation re: various assertions and facts regarding Humana Hospital Sunrise

95. 4/12/84 opinion of the Attorney General re: Humana's proposed practices of eliminating deductibles and/or copayments when the insured utilizes a particular hospital

96. Key Ratios Comparisons - Nevada Hospitals vs. National Average - Inpatient only

97. 1/28/87 letter from Dr. Soper to Fellow Physicians of Humana Hospital Sunrise and Medical Staff

98. 3/13/87 Marketing and Public Affairs Campaign for Humana Hospital Sunrise prepared by Nelson/Padberg Communications

99. 5/15/87 letter from David Jones to Colleagues enclosing his remarks when announcing steps taken to the protect Humana against regulatory harassment by the Bryan Administration

100. 5/15/87 memo to the file from Joseph A. Murray, Chief Investigator - Insurance Fraud Unit re: meeting with F.B.I. personnel

101. 9/18/87 Memo from Joe Shutts to Rob Leo re: Humana Care Plus Patients for Sunrise

102. 9/9/87 Memo from Joe Shutts to Larry Cash re: Humana Care Plus Patients for Sunrise

103. 12/30/87 Memo to Larry Cash from Douglas R. Carlisle re: Meeting with Nevada Department of Insurance

104. 4/1/88 Memo to Mike Manges for Joe Lawrence re: renewing Groups After January 1, 1988

105. 12/13/88 letter from Don Penney, Associate Actuary to State of Nevada, Department of Commerce, Life & Health Division re: UCR Schedules of Humana Medical Plan of Nevada, Inc.

106. 3/89 Narrative Report of the Enrollee Attitude Study Concerning Humana Hospital Sunrise prepared by The Gallup Organization, Inc.

107. 3/8/89 Memo to Neal Westermeyer, John Seagle from Elroy Schuler re: Las Vegas Class Action Suit Study

108. 3/10/89 Memo to Don Stewart from Paul Carter, Medicare Manager - Humana Gold Plan re: Affects of Adverse Publicity

109. 3/22/89 Memo from Neal Westermeyer to Wayne Smith re: Las Vegas Awareness of negative publicity surrounding Humana Hospital Sunrise

110. 3/20/89 Memo to Neal Westermeyer from Judi Farmer Re: Las Vegas Awareness

111. 3/9/90 letter from Donald Stewart to Jerry Griepentrog setting forth Humana's Position on the Definition of "Billed Charges", Inclusion/Exclusion of Medicare and Medicaid Patients and Percentage of Increase in Gross Revenue per Admission Attributable to Increase in Acuity

112. State of Nevada - Big Six Hospitals, Financial Summaries

113. 7/12/90 memo from Gary Pullen to Trevor G. Smith re: Humana Insurance Company

114. 1988 newspaper article entitled "UMC to cite Humana for Refusing Treatment"

115. Newspaper article from the "Capsule" entitled "Successful test of insurance spells expansion"

116. Graph depicting Comparison of Nevada Hospital Data to Consumer Price Index

117. Information regarding Acute Care Hospitals Markup Ratio, Operating Margin Comparisons

118. Desert Springs Hospital, Humana Hospital Sunrise, St. Mary's Regional Medical Center, University Medical Center, Valley Hospital Medical Center and Washoe Medical Center Comparison of Payor Categories, 6 months ended 12/31/89

119. Notes and Assumptions in Compiling Information for Comparison of Payor Categories

120. Hospital Comparisons for the period 1/1/88 to 12/31/88 Ranked by gross revenue per stay

121. Nevada Major Urban Hospitals - Per Patient Day Information - Billed Charges

122. Key Ratio Comparisons - Nevada Hospitals vs. national Average - Inpatient Only

123. Newspaper article entitled "Humana Policy Known for Three Years"

124. Nevada Hospital Financial Quarterly Report - 1985

125. 8/12/86 L.F. Rothschild, Unterberg, Towin, Inc. basic report

126. 5/30/89 Memo to Dave Gates from Sharon Weaver re: Humana Health Plan, Inc. (proposed foreign HMO)

127. 5/2/89 Memo to Mr. Schmoutz from Sharon Weaver re: Review of the GP 1000 policies and enclosing information.

128. 5/2/89 letter from Margaret Thomas, Contract Analysis to Sharon Weaver of Insurance Division re: Merger of Humana Health Insurance of Nevada, Inc. into Humana Insurance Company

129. Nevada State Quarterly Report, Comparison of Calendar Years 1985 and 1986

130. Nevada Hospital Quarterly Report dated 10/17/87

131. Nevada Hospital Quarterly Report dated 2/3/88

132. Nevada Hospital Quarterly Report dated 4/29/88

133. Nevada Hospital Quarterly Report for the period 7/01/88 through 9/30/88

134. Nevada Hospital Quarterly Report dated 7/21/88

135. Nevada Hospital Quarterly Report dated 10/26/88

136. Nevada Hospital Quarterly Report dated 1/30/89

137. Nevada Hospital Quarterly Report dated 2/21/89

138. Nevada Hospital Quarterly Report dated 4/28/89

139. Effect of Billed Charges Rollback/Revenue Reduction Program based on 1986 Inpatient Financial Information

140. Analysis of AHA Statistics - 1986 Utilization

141. 5/20/87 Nevada Hospital Association - Testimony Before the Senate Human Resources Committee - AB 289 Proposed Amendments

142. 9/16/87 Memo from Rob Leo to Steve Monaghan re: Methodology for Base Year Net Revenue for 7/1/86 to 6/30/87 including summary of consolidated operating results for the three months ended November 30

143. 1/17/85 letter to Dennis Kennedy from Glen A. Reed, counsel to Desert Springs Hospital re: Humana Care Plus Insurance Plan

144. Various reports including In-Patient Utilization, Enrollment/Premium Statistics, Benefit Level Options for groups of 50+, Budget Income Statement Summary dated 4/85

145. Memo re: definitive statement as to how the disincentive is applied

146. July 8-10, 1985 Utilization Review Assessment, Las Vegas Market - General Findings

147. 8/21/85 memo from Dave Shoughrue to All Sales and Operations Managers re: Competitive Information

148. 3/3/88 Memo from Rob Leo to Gary Hill enclosing analysis of pre-tax implications of an HPN contract for 20,000 patient days

149. 12/6/88 memo from Rob Leo to Marty Schweinhart re: Culinary Contract with attached pro forma

150. Humana Hospital Sunrise H.C.P. Analysis, AB 289 Adjustments, Pathology Analysis - I AB-289, Humana Care Plus Analysis for July, 1986 through June, 1987, Humana Hospital Sunrise Humana Care Plus Analysis for July, 1988 through June, 1989

151. 7/18/84 transcript of hearing re: Certificate of Authority of Humana Health Insurance of Nevada -- Valley Hospital Medical Center, Petitioner

152. 11/13/87 letter from John Egermayer to Robert Evans, Insurance Division re: transfer of claims processing and payment from Mutual Administrators, Inc. to Humana Corporate Claims System, Louisville, Kentucky

153. Telephone message to Herschell from John Andris re: merger and documents regarding exam

154. 3/9/84 letter from FIB to David Reinhardt, Humana Investment Management Department re: receipt of $1,501,355.63 via wire transfer

155. 10/20/88 Agreed Upon Procedures Review of Humana Organization prepared by Laventhol & Horwath

156. 7/21/89 Report of Examination to Determine Compliance with AB 289 and AB 278

157. 7/26/85 Report of Examination of Humana Health Insurance

158. 9/30/88 Report of Examination of Humana Health Insurance

159. Report of Examination of Humana Health Insurance of Nevada, Inc.

160. Portions of transcripts from the depositions or hearings of the following individuals:

    a. Roger Collins;
    b. Larry Cash;
    c. David Jones;
    d. Carl Pollard;
    e. Robert Lubbers
    f. David Gates
    g. Samuel Hazen
    h. Henry Werronen

161. 29 U.S.C. §§ 1002(21), 1004(a)(1)

162. All other memos and documents referred to herein.

II. Summary of Opinion

A. ERISA Analysis

I have reviewed 29 U.S.C. § 1002(21), and understand that a person is a fiduciary with respect to an employee benefits insurance plan if that person exercises any discretionary authority or discretionary control respecting management of such plan, or exercises any authority or control respecting management or disposition of the plan's assets, or if the person has any discretionary authority or responsibility in the administration of the insurance plan.

I further understand that Judge Pro has ruled that the insurance contracts themselves are assets of the insurance plan. With that understanding in mind, and after reviewing the master contract, HCP-NV-84-1 and the Preferred Provider Agreement and its amendments (the Secret Agreement), I am of the opinion that, from an economic point of view, the Secret Agreement payment terms, specifically "Attachment B" to the Agreement, did have an economic affect on the payment provisions of the insurance contracts.

I am further of the opinion that the payment terms of Attachment B materially changed the financial obligation of Humana Insurance from what it was otherwise obligated to pay pursuant to the payment terms of the insurance contract.

I have also reviewed 29 U.S.C. § 1104(a)(1), and understand that an ERISA fiduciary must discharge its duties with respect to the insurance plan solely in the interests of the participants and beneficiaries, in accordance with the plan contracts.

I am of the opinion that a payment of hospital charges based on a percentage or a per diem to Sunrise Hospital by Humana Insurance according to "Attachment B" of the Secret Agreement was not in accordance with the payment

terms of the insurance contracts. Furthermore, I am of the opinion that payment of hospital charges based on a percentage or a per diem to Sunrise Hospital according to "Attachment B" of the Secret Agreement while calculating the working person's payment on full billed charges was not in the best financial interest of the working person.

Based on the ERISA statutes and the holding of Judge Pro in his July 8, 1991 Order that the co-payor class is entitled to the benefit of the discount arrangement, the above referenced financial information of the Defendants was reviewed to determine the full amount of the discount during the class years 1985, 1986, 1987 and 1988.

A. The damages for the co-payor class:

1. Since the Second Amended Complaint was filed I have calculated the discount received by Humana Insurance from Sunrise Hospital as set forth below.

1985:	$ 5,058,000.00
1986:	$15,621,000.00
1987:	$15,743,000.00
1988:	$13,018,000.00

The total of all such discounts for the class period of 1985 - 1988 equals $49,440,000.00.

2. Thereafter, the following interest calculations were done using a reasonable rate of return of five (5)% per annum on the total discount amount of $49,440,000 from 1985 forward, which totaled $15,396,000, using simple interest, and $15,761,000 if interest is compounded monthly. With simple interest at 5% the total co-payor damages were calculated to be $64,876,000, and if compounded monthly the total co-payor damages were calculated to be $65,201,000.

3. Defendants' alternative approach to calculating damages in terms of the amounts that co-payors actually paid to Humana-Sunrise rests on estimates by Defendants that are not reliable. In addition, proper calculation of those damages requires specific information for each co-payor that Defendants have never produced during the course of this litigation.

a. Defendants' calculations regarding the actual amounts of co-payments by class members are not reliable.

At one time in this litigation Defendants asserted in a sworn affidavit that plaintiff Marrietta Cade had paid only $87.72 of hospitals bills totaling $16,437.66:

> The records of Humana Health Insurance confirm that Robert Cade was hospitalized in October, 1987, at Sunrise and that he incurred a hospital bill in the amount of $16,437.66. All but $87.72 of that hospital bill was covered by the benefits of Group Policy 79201.

Affidavit of John R. Egermayer, dated May 30, 1989, in Defendants' Supplemental Brief in Opposition to Plaintiffs' Motion for Class Certification. During a deposition of Mrs. Cade, Defendants' counsel Paul R. Hejmanowski represented to her as follows:

> Q There's an affidavit, a written document under oath by a representative of one of the defendants who stated, in effect, that with respect to Mr. Cade's October 1987 hospitalization, that your net payment towards the hospital bill was approximately $87.00.

Cade deposition at 13 (lines 18-23). Mrs. Cade thereafter produced copies of her personal checks establishing that she had in fact paid $1,146.71 to Humana-Sunrise in 1987 rather than the $87.72 that Defendants alleged. The most striking aspect of this 1,307% error by Defendants is that if Mrs. Cade had not prudently retained her cancelled checks from

that period, Defendants' sworn statement would have gone unchallenged.

Mr. Egermayer's representations concerning hospital charges by Humana-Sunrise were incomplete as well. In addition to the $16,437.66 bill that Mr. Egermayer reported, Mr. Cade incurred another bill from Humana-Sunrise in 1987 in the amount of $1,182.60 for outpatient services. That was the charge for which Humana-Sunrise billed the Cades $146.71, an amount that Mrs. Cade remitted.

2. Defendants' estimates regarding the actual amounts of co-payments by class members include improper overpayments.

Humana-Sunrise's $146.71 charge to the Cades was improper. According to the terms of the Humana Insurance group health policy that covered the Cades, the most they were required to pay for covered medical services in 1987 was $1,000.00. Mrs. Cade paid at least $146.71 beyond that limit, an overpayment that Humana-Sunrise *to this day* has not returned. Mrs. Cade's overpayment demonstrates that Defendants cannot calculate actual copayments merely by assuming they were the lesser of (a) $1,000.00 or (b) 20% of the hospital's gross billed charges. If Defendants applied that calculation to Mrs. Cade, they would understate her copayments by $146.71.

This situation may be considerably worse with respect to co-payors other than Mrs. Cade. She wisely disregarded additional attempts by Humana-Sunrise to collect amounts greater than her coinsurance limit. Statements from Humana-Sunrise demonstrate that on one occasion the hospital demanded payment of $353.00 on Mr. Cade's inpatient charges, even though the statement itself indicated the Cades had already paid $1,000.00 toward those charges. On another occasion Humana-Sunrise demanded payment of $236.52 for Mr. Cade's outpatient charges. As noted *supra*, *any* charge from Humana-Sunrise for those outpatient services

was improper, given that the Cades had already reached their annual payment limit of $1,000.00

Other co-payors might have paid those bills, especially co-payors recovering from debilitating afflictions, or those preoccupied with the task of caring for relatives who were recuperating at home, or those in mourning for recently deceased relatives. If Mrs. Cade had paid those bills for her husband, her overpayment would have totaled $589.52, or 58.95%. In actual fact, Mrs. Cade paid both the $353.00 and $100.00 of the $236.52, then demanded refunds.

If Defendants assert that those overpayments were for non-covered expenses, then Defendants are required to demonstrate, with respect to each patient, specifically what the non-covered expenses were for. Defendants cannot merely rely on the sort of entry that appears on Humana Insurance's Explanations of Benefits (EOBs), stating that a given charge is for all non-covered items, without identifying those items and specifying the amount charged for each one. As an example, Humana Insurance sent the Cades an EOB dated May 5, 1986 that listed $6.05 in non-covered charges for "Hosp Misc" without offering any additional information. Given Humana Insurance's fiduciary obligations to the Cades, a conclusory entry of that sort was wholly inadequate, and allowing Humana Insurance to rely now on tens of thousands of similar entries would severely compound the error.

Similar examples arose in statements of accounts issued to the Cades by Humana-Sunrise. In one statement Humana-Sunrise listed a "total due" of $15,437.66, "estimated insurance" of $15,084.66, and a "patient amount" of $353.00. Another statement listed a "total due" of $1,182.60, "estimated insurance" of $946.08, and a "patient amount" of $236.52. The statements offered no additional information concerning the amounts not covered by insurance.

3. Defendants' estimates regarding the actual amounts of co-payments by class members include unfounded assumptions.

Defendants' estimates assume that Plaintiffs had to pay the lesser of (a) $1,000.00 or (b) 20% of the gross hospital charges. In many or most instances, however, a deductible applied to some of those patients' Sunrise charges. If the patient's policy required a $500 deductible, if he had incurred no medical charges during the calendar year before entering Humana-Sunrise, and if his hospital bill was $10,000, then the patient would have paid a total of $1,500 of the hospital charges — $500 deductible in addition to 20% of the $9,000.00 balance up to $1,000.00, or $1,000. If, however, that same patient had incurred $500 in medical charges before entering the hospital, he would have paid only $1,000 of the hospital charges.

The question, in other words, is what portion, if any, of each co-payor's deductible in a given year was paid to Humana-Sunrise instead of to other health care providers. Defendants cannot simply adopt some arbitrary amount and apply it as an average. A complete analysis would require determining, for each co-payor, the amount of other medical expenses the co-payor incurred prior to entering Humana-Sunrise.

A complete analysis would additionally require determining, for each co-payor, the amount of the deductible set forth in that co-payor's policy. The master policy that Humana Insurance filed with the Nevada Insurance Division indicated five deductible alternatives for Humana-Sunrise ranging from no deductible to $500.

A complete analysis would further require determining, for each co-payor, the amount of the stop-loss set forth in that co-payor's policy. The master policy that Humana Insurance filed with the Nevada Insurance Division indicated alternative stop-loss combinations involving four options per individual that ranged from $1,000 to $10,000 and four options per family that ranged from $2,000 to $20,000.

Defendants' estimates assume that each patient reached a stop-loss limit of $5,000 in billed charges. After a cursory review of paid claims for 1985 and 1986, however, my impression is that an insignificant portion of those claims reached $5,000.

Finally, Defendants are required to determine, for each co-payor, the percentage of co-payment set forth in that co-payor's policy. The master policy that Humana Insurance filed with the Nevada Insurance Division indicated four co-payment alternatives ranging from 10% to 40%. Although Plaintiffs are not aware of any group policies issued by Humana Insurance that required copayments other than 20%, Plaintiffs have not examined each of the thousands of policies at issue and cannot simply rely on an assumption by Defendants that all of them specified that percentage.

B. The damages for the premium payor class:

1. Based on the Annual Statements filed by Humana Insurance with the Nevada Insurance Department, I am informed and believe that the total premium charged by Humana Insurance in Clark County during the time period 1985 through 1988 was the following:

1985:	$21,434,100
1986:	$33,393,670
1987:	$29,065,217
1988:	$28,861,525

During the class period, 1985 through 1988, premiums totaled $112,754,512.

Assuming that the actuarial formula did not include an adjustment for any Sunrise Hospital discount, under the actuarial formula adopted at the hearing before the Insurance Department in 1984, premiums would have to decrease by 48% if the 89% discount had been constant during this time period. Stated another way, since the difference between no

discount and the actual discount given is 89%, and given 68% of the expenses were allocated to the hospital in the actuarial formula (reduced by the assumed 20% non-Humana hospital utilization in the actuarial formula because these projected non-Humana hospital billings would not be impacted by the "secret" discount), an additional 89% discount would produce roughly a 48% reduction (68% hospital adjusted by 20% non-Humana times 89% discount) to premiums.

If a 48% reduction is applied to these premium charges, the total reduction is $54,122,165. It should be noted that this figure approximates the total reduction that should be applied because the evidence suggests that hospital discounts were under 89% for a portion of the pertinent time period and exceeded 89% during certain pertinent time periods. It should further be noted that if the per diem charges for the GP-1000 series were $600 per diem as opposed to $125 per diem for the HCP-NV-84-1 (which some evidence suggests), this damages figure is slightly overstated depending on the amount of 1988 premiums allocated to the CP-1000 series and the differential between a $125 per diem and a $600 per diem.

2. If, on the other hand, Humana Insurance did incorporate a 30% discount into the actuarial calculation (despite evidence to the contrary), the premium damages would be slightly lower. If the hospital discount is increased to 89% under the actuarial formula adopted by Humana Insurance at the 1984 hearing, premiums would have to decrease by 32%, if the 89% discount had been constant during this time period. More fully, since the difference between a 30% discount and a 89% discount is 59%, and 68% of the expenses were allocated to Humana Hospital in the actuarial formula (reduced by the assumed 20% non-Humana hospital utilization in the actuarial formula because these projected non-Humana hospital billings would not be impacted by the

"secret" discount), an additional 59% discount would produce roughly a 32% adjustment (68% hospital adjusted by 20% non-Humana times 59% discount).

If a 32% reduction is applied to these premium charges, the total reduction is $36,081,443. It should be noted that this figure approximates the total reduction that should be applied because the evidence suggests that hospital discounts were under 89% for a portion of the pertinent time period and exceeded 89% during certain pertinent time periods. It should further be noted that if the per diem charges for the GP-1000 series were $600 per diem as opposed to $125 per diem for the HCP-NV-84-1 (which some evidence suggests), this damages figure is slightly overstated depending on the amount of 1988 premiums allocated to the GP-1000 series and the differential between a $125 per diem and a $600 per diem.

In summary, the premium payor damages, without interest, are $54,122,165.00 if a 30% discount was not passed on, and $36,081,443.00, without interest, if a 30% discount was passed on.

3. Interest on the premium class damages were calculated by using a rate of return of 5%. Computing simple interest at 5% per annum on $54,122,165.00 resulted in interest damages of $16,479,815.00 for total premium payor damages of $70,601,980.00.

Compounding interest monthly, using the above stated rate of return, resulted in interest damages of $16,908,-730.00, for total premium payor damages of $71,030,-895.00.

Computing simple interest at 5% per annum on $36,081,-443.00 resulted in interest damages of $10,986,542.00, for total premium payor damages of $47,067,985.00.

Compounding interest monthly, using the above stated rate of return resulted in interest damages of $11,272,487.00 for total premium payor damages of $47,353,930.00.

C. Hospital Costs

1. Nevada Hospitals Lead the Nation in Profitability During the Class Period

I have reviewed the 1987 and 1988 Annual Survey by the American Hospital Association, wherein Nevada hospitals are number one in the United States in terms of hospital profitability. The American Hospital Association's 1987 Annual Survey provides in pertinent part that the profit per day of Nevada hospitals was $63.44, the billed charges per day were $1,248.00 and the net revenue per day were $829.52. By way of comparison, the net national average for profit per day was $23.37. Nevada hospital profits per day were 270% higher than the average in the entire United States. Arizona, which borders Nevada, was ranked 23rd with profit per day of $26.23, billed charges per day of $929.33 and net revenue per day of $689.98.

A document titled "Analysis of AHA Statistics — 1986" [12017319] reported that Nevada hospitals ranked first in the nation per admission in billed charges, net revenue, and profits. The profits per admission for Nevada hospitals was $274. The second highest state had profits per admission of $133 — less than half as high as those in Nevada. It is interesting to note that the three most profitable states, Nevada, Florida, and Kentucky, are all Humana strongbeds.

The American Hospital Association's 1988 Annual Survey reports that the profit per admission of Nevada hospitals was $306.93, the billed charges per admission were $8,009 and the net national average for profit per admission was $146.36. Nevada hospital profits per admission were twice as high as the average in the entire United States. Arizona,

by contrast, was ranked 43rd with profit per admit of $82.14. In other words, crossing the state lines from Arizona to Nevada caused a 273% increase in profits per admission.

A report prepared by the State of Nevada entitled "Proposal for an Integrated Approach to the Nevada Health Care Issues" stated: "That Nevada currently has the highest hospitals costs in the nation is not a debatable issue. Every available data source has consistently ranked Nevada hospitals first in billed charges, net revenues and profits." *Id.* at 1. I concur.

2. Sunrise Hospital Leads Southern Nevada in Profitability.

I have reviewed the following reports relative to revenues of for profit hospitals in Southern Nevada:

a. Report from the Nevada Division of Health Resources titled "Nevada Major Hospitals: 1986 Information".

This report determined Humana Sunrise had the highest billed charge per day, $1,671.00. However the net revenue is not the highest in large part due to the discounts to Humana Insurance. This is evidence that the discounts materially affected the true profit picture for Sunrise Hospital by falsely depicting that Sunrise was not as profitable as it really was during this time period.

b. Report from the Nevada Division of Humana Resources titled "Hospital UB 82 System Information for the Period January 1987 through July 1987".

This report determined that Humana Sunrise had the highest average per charge, $4,559.00 of all for-profit hospitals in Southern Nevada.

c. Report from the Nevada Division of Humana Resources titled "Comparative Analysis of Hospital Data for 1987 and 1988."

Again, this report reflects the fact that Humana Sunrise had the highest gross revenue per patient of the for-profit Southern Nevada hospitals.

A Humana document titled "Key Ratios Comparisons" reported that Humana-Sunrise's return on investment as of December 31, 1986 was 42.2%, compared to 35.5% for Desert Springs Hospital and 31.5% for Valley Hospital. The national average was only 10.3%.

An example of the profits Sunrise was able to generate in Nevada is dramatically illustrated below. For the year 1986 the following information clearly shows the higher profit Sunrise was able to generate as a percentage of the entire Humana parent company's United States operation.

Per Laventhol report at ii		
Consolidated parent company income before income tax	$90,652,000	100.0%
Humana Sunrise income after add-back of home office costs and Humana Insurance discounts per Laventhol report	$39,891,000	
Humana Health Insurance of Nevada losses per annual report	$(2,812,000)	
Add-back of home office at 2.4% of revenue of $33,394,000	$ 801,000	
Combined Income Before Income Taxes	$37,880,000	41.7%

The combined income of $37,880,000 of Humana Insurance of Nevada and Humana Sunrise as compared to the combined income of $90,652,000 for all Humana operations in the United States, clearly shows that Humana Sunrise and

Humana Insurance of Nevada generated approximately 41.7% of the income of all Humana operations.

3. Humana's Denial of Sunrise's Leading Profitability Is Not True.

I have also reviewed the deposition testimony of David Jones as it relates to the profitability of Sunrise Hospital compared to other Humana hospitals. I specifically reviewed the testimony of Mr. Jones related to an internal memo from George Atkins to Mr. Jones concerning the Nevada Cost Containment legislation, and Mr. Jones' response to then-Governor Richard Bryan's efforts relating to cost containment. Mr. Jones responded to questions about his handwritten notations on the memo as follows:

Q. . . . And number three says, "When will we get to the substance, i.e., the Governor is lying for personal gain."

What did you mean by that?

A. I meant that he was demagoging the issue.

Q. And, for the record, would you explain your answer when you say demagoging the issue?

A. I think it's -- I don't believe I could say it any plainer than it's written here.

"i.e., Governor is lying for personal gain."

That's what I mean by demagoging it.

Q. Well, I guess what I was wondering, what was behind that statement. . . .

A. He was saying a lot of untrue things about our organization.

Q. Specifically, do you recall what he was saying that you took issue with? I mean, not the generalities, what

particular things did he say that you felt were just not true?

A. I would have to go back and check. I remember being very concerned that the things he was saying did not reflect the truth.

Q. O.K. Would it refresh your recollection if I indicated to you it's my understanding that the Governor was concerned that Nevada had very high cost and felt that the hospitals in Nevada were making too great a profit?

Do you recall anything in his allegations along those lines?

A. I do recall something about that, now that my recollection has been refreshed. He had made some outrageous claim about the profitability of our activities out there, which was just not true.

Q. Humana accounts for a -- Humana Sunrise, excuse me, accounts for a large portion of Humana's overall pretax profit on an annual basis; does it not?

A. What do you mean by large?

Q. Above ten percent?

A. I don't think so, not near ten percent.

Q. Do you know if it's ever amounted to forty-four percent of your reported pretax profit?

A. The -- it's never amount to forty-four percent of the profits of the profitable parts of our business.

In the year in which we took the large writeoff, which was over a hundred million dollars after tax, and closer to two hundred million dollars before tax, that reduced the total company profits to something like fifty-six million dollars, and there were many hospitals

in that year which were quite profitable that weren't related to the insurance writeoffs that we've talked about, so that you could have said as of any hospital that was profitable, that its profit compared to the total profit of the company was large.

But if you added all those percentages up, it would have come to a figure many times the total profit of the company. It was only because of the writeoffs in that -- in that year.

Q. So, am I understanding you to say, in essence, that the pretax profit reported by Humana Sunrise was not taking into consideration the pretax profits of the entire company?

A. I'm saying you're putting apples and oranges together.

In that year, 1986, all of the hospitals together had a profit that was substantially greater than the two hundred million dollars of writeoffs, and that if you subtracted -- let me just say that among the profitable parts of the company, among the hospital division, the Nevada hospital profits were nowhere near forty-four percent.

Q. Let me see one moment here.

The reason I brought that figure up is because I had seen that in a report that was generated by Laventhol & Horwath that indicated those numbers, and, apparently, got those from the Annual Statement of Humana, Inc., and the statements -- or Annual Profit and Loss Statement from Humana Sunrise.

A. I just explained exactly how it occurred.

Q. I understand what you're saying, but I want to make sure that you can look at the document and after having seen the report, see if again that conforms to

your understanding of where the State of Nevada got those numbers. . . .

Mr. Jones, . . . I'm going to show you a binder that I'll refer to the Exhibits "M" as in master documents, which is on the spine. And, that is M-14.

(Whereupon the above-mentioned instrument was tendered).

And, ask you to look at the third page of the analysis, when you get it -- yeah, you're on it -- and it's the first indented paragraph under the paragraph at the top, "In 1986, the consolidated pretax income."

Do you see that, sir?

A. Yes, I see it.

(Witness complies with request of counsel.)

Q. Again, after having looked at this statement by Laventhol & Horwath, does that coincide with the analysis you just gave me as to where Laventhol came up with the numbers?

A. I can't speak for Laventhol. I don't know anything about Laventhol. But I can tell you -- there's two things.

First, the amount of pretax profit for Sunrise Hospital is itself misleading, because it doesn't include the totality of the operations that comprise the activities there -- the office buildings; the outpatient centers -- they've taken one entity and taken one piece of one entity to get the profit of the -- of this -- what they call Sunrise.

So, there's a deception in that.

The second thing --

Q. Just to clarify --

A. The ninety million dollars of pretax profit is after the writeoffs that I described to you.

All the hospitals together would have created percentages that came to many times a hundred percent, if this methodology were used.

This is comparing apples and oranges.

Q. Right. And, like I said, I wanted to make sure that you could look at this, and so you could -- after having looked at this, go through this same analysis and make sure I understood you.

But going back to the one thing you said about the thirty-nine million dollars, that being just Sunrise Hospital. How do you -- as opposed to the other related buildings and operations, how do you know that from this particular document?

A. Because I've heard this canard before.

. . .

Q. Did you understand that after the writeoffs in 1986, approximately -- obviously, you don't have it here in front of you -- that the pretax profit of Humana, Inc. was around ninety million dollars?

A. I believe that that's what this means. But when it says Sunrise in that phrase, the profit reported for what I call Sunrise, which is that bundle of assets that compromise the hospital and its attendant, contiguous, integrated operations -- I'm not talking about insurance, now, I'm just talking about the operation of the hospital and the medical office buildings and the outpatient centers around there -- the figure is inflated.

Q. Do you know how much it's inflated by?

A. Somewhere in the neighborhood of five to ten million dollars.

That was one of the complaints I had about the Governor, because this was the -- this is one of the lies that the Governor was telling, that Sunrise Hospital was contributing some enormous proportion of the company's profits, which was simply not true.

Q. Would you agree, then, that the forty-four percent of the profits, if they had been contributed by one hospital out of eighty-seven, would have been an enormous amount, using your term of the word enormous?

A. It would have been a very significant amount.

. . .

Q. And the reason that that impression is incorrect is, at least in your mind, is because of the huge losses that Humana suffered on the insurance side?

A. That's nothing necessarily to do with what the condition is.

What it's untrue is, because if you took the percentage of the ninety million dollars contributed by each hospital, it would come to far more than one hundred percent.

Q. Oh, I see.

A. Therefore, no one hospital could conceivably have contributed the percentages claimed.

. . .

Q. O.K. There's another statement in the last sentence of this paragraph we were just discussing that Sunrise was also Humana's most profitable hospital in 1985.

Do you know if, in fact, Humana was -- or excuse me, I got that backwards -- if Sunrise was Humana's most profitable hospital in 1986?

A. I don't recall. I testified earlier that it tends to be number one, two or three, and that the market tends to be in the top five.

. . .

There are several statements made by Mr. Jones which I believe to be inaccurate. First of all, he says that the Governor is lying because Sunrise does not account for a large portion of Humana's overall pretax profit. Specifically, he says it does not account for even "near ten percent".

Furthermore, when presented with the report prepared by Laventhol & Horwath for the State of Nevada, on which Governor Bryan was apparently relying, Mr. Jones states that the pretax profit for Sunrise is misleading and deceptive because it doesn't take into account the writeoff incurred by the Insurance Division in 1986, and doesn't include the "totality of the operations that comprise the operations [in Nevada]."

As set forth in full in Section C(2) above, I believe that Sunrise contributed far more than ten percent (10%) of the parent company's (Humana, Inc.) pretax profit, and that the report of Laventhol & Horwath, for the most part, takes into consideration the issues raised by Mr. Jones in reaching a conclusion. In fact, in my opinion, if anyone was being deceptive in analyzing profitability, it was Sunrise because it appears that it was trying to shift approximately $15,000,000 in secret discounts to what should have been Humana Sunrise's profits during a time of cost containment legislation, thereby artificially reducing the true profit picture for the Hospital.

Furthermore, some of Humana's own documents confirm the enormous profitability of Sunrise year after year. For the year 1985 the State of Nevada, Department of Human Resources and the "Medicare Intermediary Audit of Home Office Costs" indicates that Sunrise was the revenue leader:

HOSPITAL	BEDS	BILLED CHARGES	CONTRACT ADJ – BAD DEBT
Sunrise, NV	679	$194,272,000	$(70,031,000)
Biscayne, FL	402	$ 60,640,000	$(23,581,000)
Augusta, GA	362	$ 64,132,000	$(18,431,000)
Phoenix, AZ	300	$ 46,551,000	$(9,628,000)
S. Brow, FL	269	$ 24,535,000	$(4,809,000)
Ft. Walton, FL	263	$ 45,048,000	$(14,419,000)
Hoffman, IL	249	$ 47,446,000	$(9,632,000)
Cypress Gd., FL	245	$ 37,385,000	$(10,034,000)
Mt. View, CO	241	$ 23,789,000	$(5,965,000)
Bayside, VA	237	$ 44,968,000	$(16,842,000)
Lucerne, FL	232	$ 65,719,000	$(15,379,000)
St. Pete, FL	219	$ 39,203,000	$(13,827,000)
Daytona Bch, FL	214	$ 25,222,000	$(6,894,000)
Brandon, FL	204	$ 52,843,000	$(14,034,000)
St. Lukes, VA	200	$ 36,258,000	$(12,975,000)
Sun Bay, FL	192	$ 36,810,000	$(20,771,000)
Aurora, CO	189	$ 36,810,000	$(5,632,000)
Bennett, FL	178	$ 52,408,000	$(17,112,000)
Clinch Val, VA	135	$ 40,802,000	$(14,384,000)
	5,010	$974,841,000	$(304,380,000)

Finally, a Humana comparison by profits per admission "study group" again concludes that Sunrise is unquestionably the profit leader in the chain. In the report marked "received", January 7, 1987, the report concludes:

> When compared to the average for all Humana hospitals in the study group, Humana Sunrise in Nevada clearly shows a disproportionate revenue and profit picture on a per admission basis, as follows:
>
> Thus, while Humana Sunrise's operating expenses per admission were just 125.8% of the group average, its profits per admission were 229.5% of the average for all Humana hospitals in this study group.

Apparently, even Humana, Inc. could not understand how Sunrise could be so profitable, referring to the revenue and profit Sunrise generated as "disproportionate".

4. Sunrise Is the Most Profitable Hospital on a Per Inpatient Day Basis.

I have been informed that some representatives from Humana claim that Sunrise Hospital is not the most profitable hospital for the parent company on a per inpatient day basis. In other words, I have been informed that some Humana representatives have stated because Sunrise has far more beds than any other Humana hospital it naturally generates more revenue, but when you divide the profit at Sunrise by the number of annual inpatient days, Sunrise's profits are much lower than the profits compared to some smaller Humana hospitals.

I have reviewed the Nevada Department of Humana Resource's survey of Humana Hospital chain's most profitable hospitals in 1985. Based on my review of the above, and the occupancy levels at the listed hospitals in 1985, Sunrise Hospital was the second most profitable hospital of all Humana hospitals on a per inpatient day basis, with the exception of Humana's Aurora, Colorado hospital.

My calculations indicate that Sunrise generated a profit of $238.00 per inpatient day, while Aurora generated a profit of $256.00 per inpatient day. The next closest hospital was in Lucerne, Florida, generating a profit of only $200.00 per inpatient day. However, on review of other Humana internal memos provided to the State of Nevada, it was determined that Humana's Aurora, Colorado hospital did not have a symbiotic relationship with a Humana Insurance Company in 1985, and consequently no discounts were provided to the Aurora, Colorado hospital. If Sunrise had not given approximately $5,000,000 in discounts to Humana Insurance in

1985, then Sunrise would have far outstripped Aurora, Colorado as the most profitable hospital per inpatient day in Humana's chain in 1985.

D. Sunrise Claimed Incremental Costs of $125.00 Per Diem.

During the deposition of Gary Metcalf, he claimed that the $125.00 per diem Sunrise Hospital agreed to accept from Humana Insurance, starting in 1986, was sufficient to cover the hospital's incremental costs incurred per Humana insured inpatient. Other Humana representatives appear to have verified this fact, including the Humana Group Health Insurance Vice President of Finance, Larry Cash.

> I recognize $125 is considered an incremental cost. . . ."; $125 was a rate we adopted to try to make sure there would be no profit left in the payment rate to the hospitals.

Cash Deposition at 227. Mr. Cash also testified:

> Q. I guess where this all stemmed from is, you said you had an unusual discount arrangement in 1986 because you recognized a huge loss in the group health division, correct?
>
> A. No. What I said was in 1986 we increased the discount because we set up a large reserve for losses in the future. We increased the discount which brought the reserve down and that became the payment rate from that point forward.
>
> The reason we increased the discount was, in our opinion *we had to eliminate all the potential profit* from the consolidated into Humana. And if we would have kept the payment rate that was adopted or in place prior to setting up the reserve, there would still have been profit left on the books at hospital so we had to eliminate that transaction *so it would not look as if*

> *from an accounting perspective we set up a reserve which called for payment rates from the insurance company to the hospital and then the hospital then make a profit off of that payment rate.*

Cash deposition at 223-24 (emphasis added).

If in fact Sunrise covered its incremental costs with the $125.00 received from Humana Insurance, then any deductible paid by the insured working person to Sunrise, and any portion of the 20% coinsurance of the full billed charge that Sunrise received from the Humana insured working person, was profit to the hospital.

This arrangement would have the effect of allowing the hospital to cover its costs and possibly even make some profit, while the insurance entity would have a great competitive advantage over other insurance companies by paying *far* less for its insured's hospitalization.

E. Humana Insurance Profited by Withholding or Delaying Payments to Non-Humana Hospitals, including Valley Hospital and Womens Hospital.

Humana Insurance adopted a practice of withholding or delaying payments to non-Humana hospitals, including both Valley Hospital and Womens Hospital, as early as November of 1984. In an interoffice memorandum from Joe Lawrence to John Morse dated November 19, 1984, he noted: "I have also instructed Mutual Administrators to notify me of any claims filed from a non-participating hospital before they initiate payments if benefits would exceed $500.00." *Id.* at 2.

In an interoffice Humana memorandum from John Morse to "All Market Operations Managers" and copied to Henry Werronen, Richard Mastaler, and Larry Cash, et al., dated March 22, 1985, Mr. Morse directed:

> All of our group insurance and prepaid health plan contracts contain a provision stipulating that waivers, rebates, discounts and other amounts which the covered individual is not obligated to pay are not considered covered benefits. Therefore, the disincentive deductible and copayments are applied after the amount waived or discounted is excluded from the total bill.
>
> If the competitor hospital "waives" the required copayment and deductibles due from the covered Humana Care Plus enrollee, these would be eliminated from covered charges and we would apply the deductibles and copayments to the remaining balance. In effect, we would take the deductibles and copayments twice and if the second deductibles and copayments were waived we would take them again and so forth. The patient must pay the deductibles and copayments for them to be considered covered benefits whereby we would pay the remaining portion after the deductibles and copayments have been paid by the covered individual.
>
> Any hospital which publicly communicates that they will be waiving copayments and deductibles for Humana Care Plus patients should be told of this feature and how we are planning to administer it. *At the present time we are pending all claims from non-participating hospitals and in the case of deductibles and copayments being waived, these claims will be paid as described above.*

Id. at 1 (emphasis added). In a responsive interoffice Humana memorandum from Larry Cash to Henry Werronen and John Morse, et al., dated March 29, 1985, Mr. Cash directed managers to provide "a listing at the end of each month . . . indicating the hospital, market, total charges, and total covered charges for *any claims for which we are*

not paying as a result of non-participating hospitals waiving disincentive deductibles and copayments." *Id.* at 1 (emphasis added).

In an interoffice Humana memorandum from Joe Lawrence to Karen Sholtis, copied to John Egermayer, dated May 31, 1985, Mr. Lawrence noted, at 1:

> Local hospitals continued to waive our disincentive and co-insurance. I feel I need some legal direction since they are not formally waiving the charges, in fact they are billing the individual for the full amount not paid by our insurance company, however there has been no evidence that they make any efforts to collect the disincentive portion from the member.

In an interoffice Humana memorandum from Joe Lawrence to Pam Peale dated August 16, 1985, Mr. Lawrence directed: "Please pend all payment of claims from Valley Hospital and Womens Hospital for Humana Care Plus insurends until further notice." *Id.* at 1.

Three days later, in an interoffice Humana memorandum from Joe Lawrence dated August 19. 1985, Mr. Lawrence directed: "All waivers received with services performed at Valley Hospital or Women's Hospital will be *investigated, but not returned to Mutual Administrators with a decision until further notice*." Id. at 1 (emphasis added).

In a letter from Joe Lawrence to Tom Peacock, Director of Personnel for the Sahara Hotel & Casino, dated August 22, 1985, Mr. Lawrence attempted to pressure the Sahara into persuading its employees not to use non-Humana hospital facilities, especially those that waived their charges to insured patients:

> After six months into the contract with your group, we find that you utilization of Humana Hospitals is only 56% of the hospital claim dollar. If this trend continues

> it will result in an extra 5% increase in your premium at the end of the year.
>
> I feel that the major problem is that your employees have been misled by competing hospitals. Many hospitals are waiving the disincentive to the employee, therefore the employee feels that there is no increased cost. However, increased use of non-participating hospitals will result in an increase of 5%. I trust you will present this information to your employees with your input.
>
> Enclosed are copies of examples of efforts by competing hospitals to use their facilities.

Id. at 1.

In an interoffice Humana memorandum from Joe Lawrence to John Morse, copied to John Egermayer, et al., Mr. Lawrence quoted at length from the letter Mr. Peacock drafted to Sahara employees in response to Mr. Lawrence's request:

> Don't hurt yourself in the long run as well as your co-workers by going to a hospital or out-patient facility other than your doctor's office or Sunrise unless it is an emergency.
>
> There are hospitals in town that are in fact waiving the penalty imposed by Humana for using hospitals other than sunrise. Some hospitals are suggesting that our type of program somehow disrupts the established relations with both physicians and hospitals. This simply is not true! You must explain that if you or a dependent must be admitted to a hospital, except in emergency situations, you will have an economic interest in going to Sunrise.
>
> The time for you to get involved in these kinds of decisions is now! Don't jeopardize this important bene-

fit which currently does not cost you any contribution. Hospital costs must be controlled. Our program can only be successful if you do your part.

Id. at 1.

In addition to the foregoing, a July 12, 1988 memorandum from Beth Grice demonstrates that Humana Insurance withheld the payment of claims from Valley Hospital, a non-preferred hospital, until Humana Insurance had proof that the patient was billed and that the patient had paid the co-payment to Valley Hospital in accordance with the punitive terms of the Humana Insurance contract. For example, in that memorandum Humana Insurance set forth the amounts recommended to be held back for Valley Hospital claims as follows:

Month	Valley Hospital Reserve
3/86	476,750
4/86	304,860
5/86	304,860
6/86	265,286
7/86	414,826
8/86	274,478
9/86	163,414
10/86	126,986
11/86	68,296
12/86	0

Not only was this practice punitive to the patient in the form of high costs, it also had the potential of ruining the patient's credit rating, as the patient is ultimately responsible for the entire bill if not paid by the insurance company. In addition to the detrimental effect to the patient, Humana Insurance also benefited to the extent it had the ability to earn interest on the funds withheld from Valley Hospital by holding those funds in a reserve account.

F. Humana Used Deceptive and Misleading Financial Reports and Documents

In reviewing the Laventhol report (#002387 and #002392) the auditors relied on the Humana Sunrise Medicare cost reports and Nevada hospital quarterly reports submitted to the State of Nevada in reconciling the hospital discounts. These reports reflect that discounts were recorded on a regular basis during the year.

In reviewing the internal memo dated September 16, 1987 from Rob Leo, it states that the Humana Insurance Company discount was changed in August of 1986 from 56% to 89% plus additional bad debts. However, this additional discount approximating $6,300,000 and an unknown amount of bad debts does not appear to be reported in the financial data provided by Humana Sunrise to the State and relied on by the Laventhol auditors. Accordingly, the Humana Sunrise reports appear to contain incomplete and misleading information.

This conclusion is further supported by the internal discount reports prepared by Humana itself in 1986 that do not indicate that an 89% discount was being taken during the majority of 1986. More specifically, Humana has produced a document entitled "Humana Care Plus" and designated as document number 02007942 which ranks the Humana hospitals by fiscal year admissions and states the total payments to each Humana hospital by Humana Insurance and the total discounts given by Humana Insurance to each hospital. The information provided for Humana Hospital Sunrise for the "YTD FY '86" period was as follows:

Revenue $13,563,900 Discounts $5,345,200

The memo to which this information is attached implies that the foregoing data is apparently for a portion of the 1986 fiscal year, (September 1985 through April 1986).

It is further my understanding that testimony of certain Humana employees describes the calculation and reporting of such discounts, including certain back-up calculations for the Quarterly Reports. It is also my understanding that discounts provided to other entities such as Blue Cross are included with the Humana Care Plus discount reported to the State of Nevada. That fact is important in order to determine the total discounts provided to all insurers or employer groups and verify if the Humana Insurance discount is included in the discount reported. The testimony regarding the discount reporting is as follows:

Q. For whom are these documents prepared?

A. The State of Nevada.

Q. Any specific agency within the State of Nevada?

A. I don't remember the exact title. You can maybe help me here. The Division of Health Resources and Cost Review, I believe.

Q. Department of Human Resources, Health Resources and Cost Review?

A. Right.

Q. And what was the purpose of preparing these documents?

A. This was a standard quarterly report that was required by this agency.

Q. And there was a quarterly report for what entity?

A. For Humana Hospital Sunrise.

Q. Setting forth what sort of information?

A. This only shows a small portion of the entire report. The entire report encompassed financials and utilization information.

Hazen Deposition at 105-06.

I have been informed that these Quarterly Reports included the discounts that Humana Hospital was providing to Humana Insurance during these particular time periods:

Q. All right. I'll begin with 6B. Will you please turn to the second page of 6B. And do you see the entry for other contractuals?

A. Yes.

Q. Is that a sub-entry under the heading deductions from patient revenues?

A. Yes, sir.

Q. Can you state what the heading other contractuals indicates?

A. That is a category for non-medicare and non-medicaid revenue deductions. It would be, for example, HMO discounts, PPO discounts, workers' comp discounts, Champus discounts, et cetera.

Q. Would that include discounts to Humana Insurance?

A. Yes.

Id. at 108.

Hazen Deposition Exhibit 5-A reflects the following discounts in calendar years 1985 and 1986:

1985 TOTAL $19,118,570 1986 TOTAL $32,282,188

Mr. Hazen testified and the Quarterly Reports attached to the deposition as exhibits indicate total contractual discounts in the following amounts for the quarters indicated:

4th Quarter 1987	$ 9,939,196	4th Quarter 1988	$16,734,168
3rd Quarter 1987	$ 7,764,559	3rd Quarter 1988	$13,701,437
2nd Quarter 1987	$ 7,253,685	2nd Quarter 1988	$ 8,696,146
1st Quarter 1987	$12,188,691	1st Quarter 1988	$12,447,461
1987 TOTAL	$37,146,131	1988 TOTAL	$51,579,212

As explained above, the Laventhol & Horwath Report demonstrates that the discounts reported by Humana Insurance in the Nevada Quarterly Reports do not correspond to the discounts that Humana later claimed to have received in such quarters.

Additional evidence exists which appears to demonstrate further Humana's willingness to file incomplete and/or deceptive financial information with government agencies. For example, in a memo dated February 1, 1985, Humana Insurance appears to be very concerned that Humana Sunrise financial data (through the three-month period ending 12-31-84) reflects a net income of $3,500,000.00 after the losses from the physician buildings and an allocation of 48% for federal taxes.[1] Keeping in mind that during the 1985 legislative session the first real attempt was made to establish hospital cost containment regulations, these profits would have been $14,000,000 *NET OF BUILDING LOSS AND TAX*. If we compute profit before the 48% tax it is $7,300,000.00 for the three months or $29,200,000.00 on an annualized basis. Having been personally involved in the legislative committee hearings on cost containment in 1985, I know that at that time hospitals in Nevada were concerned about appearing to have generated high profits.

In light of the February 1, 1985 memo regarding Sunrise's very significant profits and the reference to the political realities at the time, I am of the opinion that Sunrise was attempting to distort its true profit picture to the State. This

[1] The corporate tax rate during this period was not 48%.

opinion is borne out in the letter dated February 5, 1985 (just four days after the internal memo) to Mr. Pepe, with the State of Nevada claiming that Sunrise could not submit quarterly filings because of some unspecified SEC requirement that the filings be audited. I do not believe there is any such SEC requirement, and Humana's assertion is belied by the fact that later on, when the 1985 profits were apparently was no longer an issue, Humana did in fact make quarterly filings with the State. It is my opinion that the February 5th letter was prepared as a delaying tactic to avoid the disclosure of excessive profits which may have increased the probability of passage of cost controls in 1985 to the detriment of Sunrise.

Additional evidence of Humana's deceptive accounting practices appears in the Quarterly Reports of Humana-Sunrise that stated its parent company charged the hospital $4,241,000 for "home office" costs in 1987 and $13,058,000 in 1988. Medicare disallowed a substantial portion of the 1986 costs. I believe Medicare has disallowed or may disallow a substantial portion of the 1987 costs as well. Those grossly inflated "home office" charges allowed Humana-Sunrise to under-report its profits during those years, and demonstrate both deceptive accounting practices and abuse of the Medicare program. Similar adjustments may be required in cost containment calculations.

G. The Discount Was Treated Inconsistently for Bonus Compensation.

It even appears that Humana employees recognized the deceptive nature of the secret discounts and complained to upper management to a point that changes had to be implemented to appease those hospital managers. In other words, the government regulators were apparently given the "discount adjusted" figures, but the hospital managers got

the benefit of the real figures when it came time to compute their bonuses. The following testimony is illustrative of the point:

> Q. Going back to the early days of the starting, '84, '85, of the insurance division, was -- did you ever perceive or have indicated to you that other people perceived that there was a conflict between the insurance division getting this so-called discount and that the hospitals were giving too much and the insurance company was asking for too much?
>
> A. Let me answer that in this way. There probably was always, or excuse me, there was perhaps some perception of that on the hospital manager's part. I never could quite figure out in my mind why. Mostly because the incentive compensation plans were all based upon budgeted results and the budgeted results either did have or would be adjusted for any pricing changes that we would have made. So, it really didn't make any difference whether it came from one place or another.

Pollard Deposition, Vol. I, at 82, 84. Mr. Cash also testified that Humana Hospital adjusted bonus compensation to hospital employees to circumvent the impact of the retroactive discount change in September of 1986:

> Q. Do you recall that it was ever adjusted based on the discounting practices at any time? The adjusted meaning the -- do you recall if the incentive bonus was ever adjusted due to or because of the discounting practices between the insurance company and the hospital?
>
> A. To the best of my recollection, there may have been some adjustments in 19 -- for the year 1987.

This treatment of the discount for bonus calculation purposes appears to be consistent with the way Humana

treated the discount in other financial documents, i.e. the "discount" was factored into the financials whenever or wherever it benefited Humana, Inc., but it was ignored whenever it did not. This is, in my opinion, further evidence of the deceptive nature of the treatment of the discount in the financial records of Humana.

I have also reviewed the insurance policy of Humana Health Insurance of Nevada, noting that the payments are to be based on usual and customary charges and that the insurance company's payment responsibility is based on paying an amount equal to 80% of these usual and customary charges. In accordance with the contract and under generally accepted accounting principles, the insurance company would pay an amount equal to the 80% and reflect a claims paid expense equal to that amount. Similarly, Humana Sunrise would receive payment equal to the 80% and record a reduction of that patient's accounts receivable. In fact, however, due to the retroactive discounts in 1986 and monthly discounts in subsequent years, the insurance company's internal accounting records, as represented by Humana and other officials, reflected a substantially reduced claims expense and a substantially larger discount. According to Larry Cash, Humana increased its discount to 89.1% effective September 14, 1987. The Annual Statement filed by Humana Insurance for that year, however, did not reflect that substantially reduced claims expense and substantially larger discount. The actual accounting transactions resulted in a shifting of profits from Humana Sunrise to Humana Insurance. In accordance with the contract in effect for these period, the recording of these transactions is not contractually correct and, therefore, is not in conformity with generally accepted accounting principles on a company-wide consolidated basis and especially on a business segment basis.

H. Humana Sunrise Benefited Enormously from the Secret Discount.

I have reviewed documents from the State Department of Human Resources relative to its computation of compliance with AB 289 for 1988. These computations included an adjustment in the base year 1986 for the pathology carve-out due to its exclusion from 1988 net revenue. An interoffice Humana memorandum from Robert B. Leo, Associate Executive Director of Finance, to Don Stewart, Executive Director of Humana-Sunrise, dated June 10, 1987 (#178204), noted that "While compliance with a 25% gross revenue reduction is mandated, several objectives/opportunities present themselves." *Id.* at 1. Mr. Leo identified one of those "opportunities" as follows: "Pathology - Separate billing arrangements are currently being negotiated which would reduce hospital expenses and revenues." *Id.*

Humana also included an adjustment to add back the Humana Insurance Company discounts. However, the discount added back assumed the GP 1000 policy was the only policy in effect for that year, when in fact the GP 1000 appears to have been a minimal factor in that year, as is reflected within the documents sent to the State on March 27, 1989 by Mr. Egermayer (#12017127-42). In my opinion, Humana's misrepresentation of the applicable discount in 1988 was an illegal act designed to circumvent AB 289. If the State had properly computed these discounts instead of relying on Humana's misrepresentation, then Humana's noncompliance with AB 289 would have been an excess of net inpatient revenue approximating $12,500,000. Pursuant to AB 289 § 55, subsection 7, the penalty for excessive inpatient revenues is twice the amount the hospital exceeds its required limit, or in this case, $25,000,000.00.

However, the State's method of computing the noncompliance was done without regard to the increase in pa-

tient admissions from 1986 to 1988, based on the State's understanding of the statute. This methodology differs from that of Humana Sunrise personnel who apparently took the increased admissions into consideration, as set forth in the memo dated October 13, 1987 from Robert Leo (#12011969). Giving Sunrise the benefit of the doubt, I recalculated my computations above so that the State's methodology for computing AB 289 is consistent with that of Humana Sunrise, and Humana's non-compliance with AB 289 was still in excess of net inpatient revenue by approximately $9,500,000, resulting in a penalty of $19,000,000.00 to Sunrise. Consequently, Sunrise had a great economic incentive to provide the enormous discount to Humana Insurance.

I. Humana Insurance's Claims That It Shared Discounts by Reducing Premiums Are Contradicted by the Facts.

In 1989 Humana Insurance presented the Nevada Department of Insurance with documents purportedly establishing that in 1987 Humana Insurance had passed along to its insureds the discounts that Humana Insurance received from Humana-Sunrise. The documents are attached as exhibits to the 1989 Report of Examination. After a review of those documents, however, I do not believe that they establish what Humana has claimed.

The first document is titled "Humana Health Insurance of Nevada Inc./Actuarial Memorandum/Year Ending December 31, 1987," and signed by David W. Wille and Larry W. Cash on April 14, 1989. The second-to-last paragraph of this document simply asserts that the analysis contained therein demonstrates that Humana Insurance passed on to its insureds the discount that Humana Insurance received from Humana-Sunrise. That assertion appears incorrect.

The second document is titled "Humana Health Insurance of Nevada Inc./Actuarial Memorandum/Year Ending

December 31, 1988," signed on March 25 and 24, 1989, by David W. Wille and Larry W. Cash, respectively, of Humana, Inc. Column One appears to set forth actual figures and reports a loss of $888,862. Column Two, labeled "For illustration Only," incorporates two modifications to the calculations in Column One. The first modification involves adding the discount of $14,272,640 to the benefits amount in Column One to arrive at benefits that would have totaled $40,969,011. The second modification involves simply adjusting premium revenues so that the loss in Column Two is the same as the loss in Column One.

This increase in premiums is a mere hypothetical, not grounded in reality or even possibility. It is my understanding that Humana Insurance had sold long-term policies that contractually committed Humana Insurance to charging certain premiums; it could not have increased those premiums unilaterally. Additionally, Humana Insurance almost certainly could not have sold policies with premiums that high. As Mr. Cash stated in his deposition:

> Q Do you believe that the premiums to Humana Care Plus insureds in the State of Nevada would have been $15 million higher in 1986 but for the discount Humana Insurance received?
>
> A That's a hypothetical question and I'm not for sure you'd have sold the premiums under that theory . . . .
>
> Q But you don't know if it would have been by $15 million?
>
> A What I'm saying is, I don't think we would have sold the premiums at $15 million higher.

Cash deposition II at 468-69.

The third document is a Statement of Actuarial Opinion prepared by James M. McCready of Coopers & Lybrand,

dated April 15, 1989. In that document Mr. McCready appears to state only that he reviewed the discount amounts and agrees that they were 90% and 75%. He does not appear to offer an opinion regarding whether those discounts were passed on in the form of reduced premiums.

Mr. Cash also testified as follows:

> Q. Okay. Did you adjust your premiums in 1986 then to reflect more or what your experience had been so that the premiums then would, in fact, cover future claims?
>
> A. Premiums in 1986 going forward, most of the premiums in 1986 had been set and we slowed down the sales activity. And we did change our payment -- our premium rate practices in 1986. We recognized we had some losses. Sometimes we did it timely and sometimes we waited when we recognized we needed a premium *increase*.

Cash Deposition at 223, 224 (emphasis added).

The claim that the "secret" retroactive discount of 89.2% in 1986 was passed along in the form of lower premiums is also inconsistent with testimony that there was a premium increase -- not a decrease -- in 1986. (Cash Deposition at 237, lines 20-23, stating "In '86 probably a rate increase"; 433, lines 13-18, stating "I believe we were increasing premiums [in November 1986]"; November 25 Morgan Stanley Investment Research Report, stating "In our opinion, Humana recognizes the errors it made with Care Plus and is in the process of correcting them. First the company is substantially increasing Care Plus premiums wherever possible" and that "Premium rates for existing unrestricted contracts and potential new ones have gone up 20 percent and 40 percent. . . .")

J. Humana's Bookkeeping Practices and the Application of the Secret Discount Appear to be a Kickback.

As Judge Pro explained in his July 9, 1991 Order, "The agreement between Humana Insurance and Sunrise Hospital on which Plaintiffs rely specifically provided for the discount rate to be the basis of charges to the insurance company, and the usual and customary rate as a continued basis for the Plaintiffs' copayments." (Order at 13). Judge Pro further noted that "The discount agreement between Humana Insurance and Sunrise Hospital meant that, although the insurance contracts provided for the insureds to cover 20% and Humana Insurance to cover 80% of hospital costs beyond the deductible, they were no longer percentages of the same figure." (Order at 15).

The above analysis by Judge Pro is consistent, from an accounting standpoint, with my understanding of the manner in which the fraudulent scheme worked. I have reviewed the HCP-NV-84-1 policy and the Humana discount reports to verify that, in fact, the discount was applied to the billed charges as Judge Pro indicated. In my opinion, and also consistent with Judge Pro's analysis, Humana Insurance should have been paying the co-insurance pursuant to the insurance contract which clearly stated to the public the percentage to be used when paying hospital claims. In my opinion, the secret agreement is not an agreement I could rely on as a CPA as it was hidden from the buying public and strictly between officers of Humana. Accordingly, with these facts, I would probably have to conclude that the discount is in fact an illegal kickback.

Furthermore, as a CPA I may have had some obligation, if I were doing an independent audit of Humana, to inform the proper Humana officer how the discount was being treated on the books, and withdraw from the engagement if necessary. Since the discount was noted in the audit report,

the auditors must have been aware of the kickback possibility.

I am further informed that Humana Insurance actually paid Sunrise 80% of the covered charges through a checking account funded for Mutual Administrators, Humana's third party administrator in Nevada. Thereafter, the insured would receive an Explanation of Benefits ("EOB") report from Mutual Administrators, or Humana Insurance, that confirmed to the insured working person that 80% of the covered charges were being paid by Humana Insurance.

This type of deception is a central characteristic of many "kickback" schemes in which the perpetrator creates a "fictitious" billing that is submitted to the victim of the scheme or is provided to monitoring authorities as the true statement for goods or services, when in reality a different payment arrangement or a "secret" discount has been agreed to between certain of the parties. For example, Humana told the buying public who bought the policy that it would pay 80% of all covered charges, the employee benefit booklet told the working person Humana Insurance would pay 80% of all covered charges, and the E.O.B. stated unequivocally that 80% of the covered charges were being paid; yet Humana Insurance secretly knew that it would get the vast majority of that money back. The differential between the true bill and the "fictitious" amount, i.e., the "kickback," is typically appropriated without any indication to the victim that a different payment arrangement or "discount" was involved.

Another indicator that this "discount" was really a kickback is the checking account arrangement Humana set up. I am informed that a so-called "zero balance" checking account was established by Humana Insurance to fund Mutual Administrator's account used to pay Sunrise Hospital the 80% of covered charges it was due pursuant to the policy.

A zero balance checking account will in fact reduce some of the lost "float" (lost use of the money) Humana Insurance would incur in actually paying 80% of the covered claims. However, Humana Insurance would still lose the use of its funds for some period of time while the checks made their way through the banking system.

From an economic standpoint, it makes no sense to pay 80% of a charge when you are responsible for only 11% of that charge. There appears to me no economic rationale for Humana's conduct of paying 80% of the Sunrise bill when it really knew it would be held responsible for only 11%, unless it was attempting to hide that fact from someone. This payment charade is further evidence to me that the "discount" was really a secret kickback.

Certain testimony of Humana employees further confirms that the "discount" was not a legitimate arms-length transaction, suggesting further that it was really a kickback that could be adjusted to whatever level was necessary for Humana's purposes.

The following is testimony from Samuel Hazen regarding the discounts provided by Humana Hospital to Humana Insurance. Mr. Hazen was employed at Humana Sunrise from August 1987 through May 1989 (Hazen Deposition at 11). Mr. Hazen testified as follows:

Q. All right. Now does this document indicate that in July of 1988 the total revenue for Humana Sunrise from patients insured by Humana Insurance was $426,140?

A. Yes.

Q. And does it indicate that there was a discount of $661,031?

A. Yes, this document indicates that.

Q. That was in July of 1988; is that correct?

A. Yes.

Q. Could you calculate for me what percentage of a discount that is, sir?

Q. I'll give you few moments if you wish. Would you like a pen?

A. I don't need a pen.

. . . .

Q. Are you calculating that in your head?

A. Yes. It's in excess of 150 percent. I don't have the exact amount.

Hazen Deposition at 39-40.

In my experience as an accountant for the hospital industry in the State of Nevada for 24 years, I have never seen a case where a hospital gave an 89%, or greater, discount off full billed charges. In 1989 the Nevada Department of Human Resources reported that the per diems charged to insurance companies by for-profit hospitals in Las Vegas other than Humana-Sunrise ranged from a low of $700 to a high of $950, far higher than the $125 per diem that Humana-Sunrise's 89% discount equalled. That large a discount would *not* seem to me, based on my experience in the industry, to be the result of an arm's-length negotiation. I would also agree with the testimony of Mr. Robert Lubbers wherein he stated:

Q. O.K. What about the number between July 1, 1987 and December 31, 1987, for renewing groups with a suggest -- or a stated discount or eighty-five point four percent; does that also shock you that it's that high?

A. After you see the first one, the second one says there's improvement and implies that some of the things the company would have done, you know, was achieving some of the goals.

Q. Well, it's the same time period, is it not? One is just for renewing groups and the other one for new business.

A. O.K. And once again I see you're starting to make assumptions, trying to help us out, and I shouldn't be.

Q. O.K. So, the ninety-six point four percent discount would be shocking, but the eighty-five point four percent would not be shocking?

A. Both the discounts shown on these papers are high, O.K., in my mind.

Lubbers Deposition, vol, II, at 247-48.

The fraudulent scheme perpetuated by Humana and Humana Insurance is further demonstrated by the fragrant inconsistencies between the amount of the discount that Humana Hospital reported to the State of Nevada in its quarterly reports and the amount of the discount that Humana Hospital later told the State of Nevada Insurance Division it had actually applied, as is set forth in greater detail above.

K. Humana Insurance Was Insolvent Without the Secret Discount.

I am of the opinion that Humana Insurance would not have been able to remain solvent but for the secret discount agreement. This is additionally evident from the fact that the discount increased dramatically in retroactive fashion in fiscal year end 1986. It appears from the financial reports that Humana Insurance realized that it was taking huge losses in 1986 and adjusted the discount in order to stay solvent. Larry Cash confirmed this in his deposition also. *See* § D *supra*.

I have reviewed the State of Nevada statutes regarding required reserves for insurance companies, and I am of the

opinion that without the secret discount being retroactively applied at 89%, Humana Insurance would have met the statutory definition of insolvency. This opinion is further supported by the rating of the National Association of Insurance Commissioners (NAIC) in 1986 of Humana Insurance, portions of which read as follows:

> A general overview analysis of ratio results and of the current year's and preceding year's Annual Statement has indicated that the company reported a net loss of $-1,969,501 and a decrease in capital and surplus from $1,432,039 to $358,697. The company's net income for the current year was reported as $-1,969,501 and included net investment income of $137,357. . . . In the opinion of the Examiner Team, this company should be accorded immediate regulatory attention based upon losses from current operation, adverse morbidity, low or worsening surplus and dependence upon surplus contribution. . . .

In her sworn deposition, Teresa Rankin, present Insurance Commissioner of Nevada, has stated:

Q Mrs. Rankin, was there a concern by the Insurance Division that Humana Helath Insurance of Nevada, Incorporated was in danger of insolvency?

A Yes there was. . . . I had met with some of our experts in the Division and also reviewed the annual statement from the prior year, so it would be year ending 12/31/85 for the domestic insurer, and according to my calculations they were about $8,000 above where they needed to be.

In other words, they were in danger of being statutorily impaired on their capital and surplus.

> In addition, their IRIS, which is the Insurancce Regulatory Information Service, that is what IRIS stands for, those regulations are produced by the National Association of Insurance Commissioners based on statutory accounting principles and five of their ratios were out of line and were not acceptable.

Rankin deposition at 24 (17) - 25 (11). The Laventhol & Horwath report stated at iv:

> The Insurance Company's operating losses for the period from 1984 through 1986 were $35,008 (1984), $1,969,501 (1985) and $2,811,737 (1986). . . . The inadequacy of the insurance premiums collected during the three year period from July, 1984 through February, 1987 are reflected in these operating losses. Furthermore, it appears that the Insurance Company would not have been solvent during this period of time except for capital contributions made by its affiliated "parent" company.

The testimony of David Gates, the Nevada Insurance Commissioner during 1986, also confirms that Humana Insurance was being scrutinized because of its financial condition. However, I understand that the Department of Insurance was not aware of the $15,000,000+ retroactive discount in 1986, and therefore Humana would have been under-capitalized or had insufficient reserves of an additional $15,000,000.00 or more than the reported amount, if the true financial picture had been presented to the State.

In addition to the high discount Humana Insurance received from Sunrise, I have also reviewed corporation minutes which indicate that the Group Health Division of Humana Inc. received additional capital contributions of a staggering $164,500,000.00 from June 1986 to June 1987.

I am also informed that approximately $11,000,000.00 of the contributed capital was provided to Humana Insurance in order to keep it statutorily solvent. These two factors -- the secret discount and the capital contributions -- in my opinion kept Humana Insurance from insolvency, thereby allowing it to continue to operate in Nevada. By continuing to operate Sunrise, Humana could continue to reap great economic benefits by reducing its stated profits in an era of legislative cost containment, even though, standing along, Humana Insurance appeared to be an economic disaster which would, by itself, not seem to justify further loss of investment.

This opinion is confirmed by testimony of Humana officials who state that the discount was an integral part of the management plan.

As the foregoing recitation of testimony demonstrates, the fundamental objective of the entire Humana Care Plus program was to divert patients to Humana Hospital, with the apparent understanding that it would cost the parent company substantial sums of money.

The former President of Humana Insurance Company stated that Humana Insurance would operate at a loss during its first three to five years (Werronen Deposition at 155-56). He further stated that Humana Insurance "had not anticipated operating at a profit at the outset" (*id.* at 163).

The fraud perpetrated through the "secret" discount has been described by Humana employees as being an "integral" part of the underlying hospital diversion scheme. The President of Humana Insurance in 1984 testified that the "secret" discount was an "integral part" of this management plan (Werronen Deposition at 78-79):

> Q. At some point later on, somebody developed an arrangement whereby Humana Hospital gave Humana insurance Company of Nevada a discount. Was that an

integral part of the management plan that you prepared for the executive committee -- Management Committee?

A. Yes.

He further stated that the "secret" discount was a fundamental concept of the Humana management plan (*id.* at 180, lines 1-12).

The President of Humana Insurance has testified that the contract with Humana Hospital Sunrise was not developed through normal negotiations because it was "an internal arrangement." (Werronen Deposition at 126, lines 15-21):

> The reason I draw that distinction is that the contract between Humana and whatever hospital we might have contracted with in Reno was a normal document. It was developed through rigorous negotiations and so forth. The arrangement with Humana Hospital Sunrise was an internal arrangement and wasn't nearly the same process. It was a different animal.

L. Humana's Consolidated Profits in Nevada Increased During the Class Period.

As stated in the preceding paragraph, although Humana Insurance may have lost money in Nevada, there appears to have been a significant benefit to the parent company in creating the insurance entity in spite of the losses it incurred.

I reviewed the quarterly financial reports submitted by Sunrise to the State of Nevada, along with certain other financial documents referred to in Section I. hereinabove, and based on that review concluded that Humana, Inc.'s consolidated profit derived from Nevada operations increased dramatically from 1985 to 1989, as set forth below:

HUMANA HOSPITAL AND INSURANCE
CONSOLIDATION PROFITS

	HOSPITAL	INSURANCE	CONSOLIDATED
1985 Base Yr.	18,374,580	(3,647,222)	14,727,358
1986	18,686,814	(4,648,437)	14,038,377
1987	28,184,000	(5,130,650)	23,053,350
1988	24,730,000	(851,950)	23,878,050
1989	34,869,000	(3,877,223)	30,991,777
TOTAL	106,469,814	(14,508,260)	91,961,554

This analysis clearly demonstrates that Humana's *combined* profits in Nevada continued to climb dramatically during the class period, belying the claim that Humana Insurance never made a profit and was passing large savings on to Nevada consumers, i.e., the class members. The fact is, Humana Insurance facilitated the consolidated entities' ability to dramatically increase their profits at the expense of Nevada citizens.

Humana's success at increasing its annual profits from 1985's $14,727,000.00 to 1989's $30,991,777.00, an increase of $16,264,777.00, is extremely impressive under any circumstances. To increase profits by the above amounts during a time of legislative cost containment is hard to believe.

J. RANDALL JONES, ESQ.
WILL KEMP, ESQ.
JONES, JONES, CLOSE
& BROWN, CHARTERED
700 Valley Bank Plaza
300 South Fourth Street
Las Vegas, NV 89101-6026
Telephone: (702) 385-4202

STANLEY M. CHESLEY, ESQ.
WAITE, SCHNEIDER, BAYLESS &
CHESLEY CO., L.P.A.
1515 Central Trust Tower
Fourth and Vine Streets
Cincinnati, OH 45202

JOHN L. CUMMINGS III, ESQ.
CUMMINGS, CUMMINGS & DUDENHEFER
416 Gravier Street
New Orleans, LA 70130

WENDELL GAUTHIER, ESQ.
GAUTHIER & MURPHY
3500 North Hullen Street
Metairie, LA 70002

ATTORNEYS FOR PLAINTIFFS

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO. CV-S-89-249-PMP (L.R.L.)

MARY FORSYTH; MARRIETTA CADE; WILLIE ANDREWS; MARY LOU BUEHLER; HELEN STAVES; RANDOLPH BRATTON; and SEARLE AUTO GLASS, INC., doing business as BEST GLASS COMPANY,

Plaintiffs,

vs.

HUMANA, INC., a Delaware corporation; HUMANA HEALTH INSURANCE OF NEVADA, INC., a Nevada corporation; and DOES I through X, inclusive,

Defendants.

MOTION FOR LEAVE TO FILE THIRD AMENDED COMPLAINT AND JURY DEMAND

Plaintiffs, by and through their counsel of record, Jones, Jones, Close & Brown, Chartered, hereby file this Motion for Leave to File Third Amended Complaint and Jury Demand. This Motion is based on Fed. R. Civ. P. 15, the pleadings and papers on file with the Court, and the points and authorities set forth herein.

POINTS AND AUTHORITIES

I

STATEMENT OF THE CASE

On March 29, 1989, Plaintiffs filed their initial complaint in this matter. On April 28, 1989, Defendants filed a Motion to Dismiss that Complaint. On September 27, 1989, this Court entered an Order effectively denying Defendants' Motion to Dismiss. On October 27, 1989, Plaintiffs filed an Amended Complaint in response to the rulings in that Order. On January 18, 1990, Defendants filed a Second Motion to Dismiss. On July 9, 1991, this Court entered an Order effectively denying that Second Motion to Dismiss. In that Order the Court granted Plaintiffs leave to file a Second Amended Complaint, and on August 12, 1991, Plaintiffs filed their Second Amended Complaint. On September 4, 1991, Defendants filed their first Answer.

II

STATEMENT OF THE LAW

Fed. R. Civ. P. 15(a) allows a party to apply for leave to amend a pleading, and provides that "leave shall be freely given when justice so requires." One authority has observed that "[s]ubdivision (a) encourages the court to look favorably on requests to amend . . . . This proposition has been reinforced by innumerable judicial pronouncements by the federal appellate and district courts alike." 6 Charles A. Wright, Arthur R. Miller, & Mary K. Kane, *Federal Practice and Procedure* § 1483 (1990). Most significantly, the United States Supreme Court declared in *Foman v. Davis*, 371 U.S. 178 (1962), that

> If the underlying facts or circumstances relied upon by a plaintiff may be a proper subject of relief, he ought to be afforded an opportunity to test his claim on the merits. In the absence of any apparent or declared reason . . . the leave sought should, as the rules require, be "freely given."

Id., 371 U.S. at 182. *See also, e.g., United States v. Webb*, 655 F.2d 977 (9th Cir. 1981); *Hurn v. Retirement Fund Trust, Etc.*, 648 F.2d 1252 (9th Cir. 1981). In *Howey v. United States*, 481 F.2d 1187 (9th Cir. 1973), the Ninth Circuit reversed a denial of leave to amend, even five years after the initial complaint was filed, in the absence of prejudice to the defendant.

Plaintiffs' proposed Third Amended Complaint is additionally a supplemental pleading pursuant to Fed. R. Civ. P. 15(d). One of the reasons for the adoption of paragraph (d) is that otherwise a plaintiff might be forced into "commencing a new action even though events occurring after the commencement of the original action have made clear the right to relief." Fed. R. Civ. P. 15 advisory committee notes (1963). That is precisely the situation here.

III

ARGUMENT

1. Allegations regarding Defendants' RICO conspiracy.

Plaintiffs file this Third Amended Complaint to allege violations of 18 U.S.C.§ 1962(d), i.e., a conspiracy to violate 18 U.S.C. §§ 1962(a) and (c) of the federal RICO statutes. In its Order of July 9, 1991, this court dismissed a portion of Plaintiffs' RICO claims pursuant to 18 U.S.C. § 1962(a). The Court adopted the rule of some federal circuits that Plaintiffs were required to establish an injury by reason of the use or investment of racketeering income. The Court concluded that Plaintiffs "have not alleged injury resulting from investment of racketeering income, and could not do so even if they had the chance to amend." Order at 38.

On August 16, 1990, after Plaintiffs had filed both their initial Complaint and their first Amended Complaint, the Ninth Circuit issued an opinion in *Reddy v. Litton Indus., Inc.*, 912 F.2d 291 (9th Cir. 1990), *cert. denied*, 60 U.S.L.W. 3057 (October 15, 1991) that addressed the requirements for establishing a *conspiracy* to violate 18 U.S.C. 1962(a), pursuant to the conspiracy portion of the RICO statutes, 18 U.S.C. § 1962(d). The court held: "[A] plaintiff must have been injured by overt acts that are themselves statutorily defined acts of racketeering in order to have standing under § 1962(d)," *id.* at 295—i.e., by the predicate act itself, and not necessarily by the use or investment of racketeering income. In other words, the injury requirement for alleging a *conspiracy* to violate 18 U.S.C. § 1962(a), (b), or (c) leapfrogs those intermediate provisions and concentrates on the predicate act itself. Accordingly Plaintiffs now wish to amend their Complaint to allege that Defendants conspired to violate 18 U.S.C. § 1962(a) and (c).

2. Allegations regarding Wendell Cherry and William Larry Cash.

The proposed Third Amended Complaint additionally joins two culpable parties to this litigation: the estate of Wendell Cherry and its administrator, and William Larry Cash. Plaintiffs' grounds for joining those Defendants are set forth at length in the attached Third Amended Complaint 5-6 and *passim*.

3. Absence of prejudice to Defendants.

Granting Plaintiffs leave to file this Third Amended Complaint will not unduly prejudice defendants, for the following reasons:

—Plaintiffs allege no new operative facts. The same transactions, occurrences, relationships, and injuries that animated Plaintiffs' earlier complaints remain at the core of this Third Amended Complaint. Hence this litigation will not assume any essential new character by reason of the allegations set forth in this proposed Third Amended Complaint.

—The additional co-Defendants were knowing, willful, and active participants in the scheme to defraud. Hence they were aware of the transactions, occurrences, relationships, and injuries alleged in this litigation even long before Plaintiffs filed their initial Complaint. Moreover, those additional co-Defendants were aware of this litigation itself from the outset thereof and of Plaintiffs' allegations therein.

—The parties to this litigation have engaged in relatively few essential depositions. By far the larger portion of those essential depositions remain to be scheduled. Plaintiffs alone presently contemplate scheduling more than twenty-five depositions hereafter.

—More than three months remain in this litigation for discovery efforts and motions. That is entirely adequate for Defendants to pursue all necessary discovery activities.

III

CONCLUSION

For all of the foregoing reasons, Plaintiffs respectfully request leave to file a Third Amended Complaint and Jury Demand in conformance with Exhibit 1.

DATED this 31st day of October, 1991.

Respectfully submitted,

JONES, JONES, CLOSE
& BROWN, CHARTERED

By /s/ Will Kemp
J. RANDALL JONES, ESQ.
JOHN W. FIELD, ESQ.
300 Valley Bank Plaza
300 South Fourth Street
Las Vegas, Nevada 89101

ATTORNEYS FOR PLAINTIFFS

RECEIPT OF COPY

RECEIPT of a true and correct copy of the attached PLAINTIFFS' MOTION FOR LEAVE TO FILE THIRD AMENDED COMPLAINT AND JURY DEMAND is hereby acknowledged this ___ day of October, 1991.

LIONEL SAWYER & COLLINS

By_____
LOUIS E. GARFINKEL, ESQ.
1600 Valley Bank Plaza
300 South Fourth Street
Las Vegas, Nevada 89101

CERTIFICATE OF MAILING

I hereby certify that on the 31st day of October, 1991, the foregoing PLAINTIFFS' MOTION FOR LEAVE TO FILE THIRD AMENDED COMPLAINT AND JURY DEMAND was served on the following by mailing a copy thereof, first class mail, postage prepaid, to:

Mark J. Biros, Esq.
CASSON, HARKINS & LAPALLO
1233 20th Street, N.W., #800
Washington, D.C. 20036

/s/ Jill S. Fletcher
An employee of JONES, JONES, CLOSE & BROWN, CHARTERED

J. RANDALL JONES, ESQ.
JONES, JONES, CLOSE
& BROWN, CHARTERED
700 Valley Bank Plaza
300 South Fourth Street
Las Vegas, NV 89101-6026
Telephone: (702) 385-4202

ATTORNEYS FOR PLAINTIFFS

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO. CV-S-89-249 PMP (L.R.L.)

MARY FORSYTH; MARRIETTA CADE; WILLIE ANDREWS; MARY LOU BUEHLER; HELEN STAVES; RANDOLPH BRATTON; and SEARLE AUTO GLASS, INC., doing business as BEST GLASS COMPANY,

Plaintiffs,

vs.

HUMANA, INC., a Delaware corporation; HUMANA HEALTH INSURANCE OF NEVADA, a Nevada corporation; and DOE CORPORATIONS I through V, inclusive,

Defendants.

ORDER

The Court having considered the arguments of counsel, and good cause appearing, it is hereby

ORDERED, that Plaintiffs may file a Third Amended Complaint.

DATED this ___ day of _____, 1991.

_____
UNITED STATES DISTRICT COURT JUDGE

Submitted By:

JONES, JONES, CLOSE
& BROWN, CHARTERED

By /s/ Will Kemp
J. RANDALL JONES, ESQ.
JOHN W. FIELD, ESQ.
700 Valley Bank Plaza
300 South Fourth Street
Las Vegas, Nevada 89101-6026

ATTORNEYS FOR PLAINTIFFS

J. RANDALL JONES, ESQ.
WILL KEMP, ESQ.
JONES, JONES, CLOSE
& BROWN, CHARTERED
700 Valley Bank Plaza
300 South Fourth Street
Las Vegas, NV 89101-6026
Telephone: (702) 385-4202

STANLEY M. CHESLEY, ESQ.
WAITE, SCHNEIDER, BAYLESS &
CHESLEY CO., L.P.A.
1515 Central Trust Tower
Fourth and Vine Streets
Cincinnati, OH 45202

JOHN L. CUMMINGS III, ESQ.
CUMMINGS, CUMMINGS & DUDENHEFER
416 Gravier Street
New Orleans, LA 70130

WENDELL GAUTHIER, ESQ.
GAUTHIER & MURPHY
3500 North Hullen Street
Metairie, LA 70002

ATTORNEYS FOR PLAINTIFFS

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO. CV-S-89-249-PMP (L.R.L.)

MARY FORSYTH; MARRIETTA CADE; WILLIE ANDREWS; MARY LOU BUEHLER; HELEN STAVES; RANDOLPH BRATTON; and SEARLE AUTO GLASS, INC., doing business as BEST GLASS COMPANY,

Plaintiffs,

vs.

HUMANA, INC., a Delaware corporation; HUMANA HEALTH INSURANCE OF NEVADA, INC., a Nevada corporation; ESTATE OF WENDELL CHERRY; FIRST KENTUCKY TRUST CO., in its capacity as administrator of the estate of WENDELL CHERRY; WILLIAM LARRY CASH; and DOES I through X, inclusive,

Defendants.

THIRD AMENDED COMPLAINT AND JURY DEMAND

TABLE OF CONTENTS

I JURISDICTION AND VENUE 1
II RELEVANT TIMES 2
III PARTIES 2
IV FIRST CLAIM FOR RELIEF (Violations of ERISA) 7
A. Negotiation of the Secret Discount 7
1. Involvement of Wendell Cherry 8
2. Involvement of William Larry Cash 8
B. Concealment of the Secret Discount 9
1. Involvement of Wendell Cherry 9
2. Involvement of William Larry Cash 10
C. Failure to Disclose the Secret Discount 11
1. Involvement of Wendell Cherry 11
2. Involvement of William Larry Cash 12
D. Submission of the Fraudulent Master Policy 13
1. Involvement of Wendell Cherry 14
2. Involvement of William Larry Cash 15
E. Sale of the Fraudulent Group Policies 15
1. Involvement of Wendell Cherry 15
2. Involvement of William Larry Cash 15
F. Promotion of the Fraudulent Group Policies 16
1. Involvement of Wendell Cherry 16
2. Involvement of William Larry Cash 17
G. Failure to Pass Along Reduced Costs or Discounts 18
1. Involvement of Wendell Cherry 18
2. Involvement of William Larry Cash 19
H. Failure to Accomplish Exclusive Purpose of Providing Benefits and Defraying Costs of Administration 19
1. Involvement of Wendell Cherry 20
2. Involvement of William Larry Cash 20
I. Failure to Adhere to Documents and Instruments Governing the Plan 21
1. Involvement of Wendell Cherry 21
2. Involvement of William Larry Cash 22
J. Failure to Discharge Duties with Diligence and Care 23
1. Involvement of Wendell Cherry 23
2. Involvement of William Larry Cash 24

K. Dealing in a Fiduciary's Self-Interest 24
1. Involvement of Wendell Cherry. 25
2. Involvement of William Larry Cash 25
L. Acting on Behalf of an Adverse Party. 26
1. Involvement of Wendell Cherry. 26
2. Involvement of William Larry Cash 27
M. Receiving Consideration for a Fiduciary's Own Account 28
1. Involvement of Wendell Cherry. 28
2. Involvement of William Larry Cash 29
N. Requested Relief 29
V SECOND CLAIM FOR RELIEF (Violations of Federal Antitrust Laws) 30
VI THIRD CLAIM FOR RELIEF (Violations of Federal Racketeering Laws) 35
A. General Allegations 35
B. Racketeering Activities 37
1. 18 U.S.C. § 1341. 37
2. 18 U.S.C. § 1343. 38
3. 18 U.S.C. § 1503. 42
C. The RICO "Enterprise" 44
1. Humana as RICO "Enterprise" but not as RICO "Person" 44
2. Humana Insurance as RICO "Enterprise" but not as RICO "Person" 45
3. The "Humana Group" as RICO "Enterprise" 45
a. Membership of the Humana Group (45);
b. Purposes and Responsibilities of the Humana Group. (45);
c. Bases for the Humana Group (46);
d. Time Period of the Humana Group (47);
e. Culpability of the Humana Group (47)
D. Violations of 18 U.S.C. § 1962(c) 47
E. Violations of 18 U.S.C. § 1962(d) conspiracy to violate 18 U.S.C. § 1962(a) 48
F. Violations of 18 U.S.C. § 1962(d) conspiracy to violate 18 U.S.C. § 1962(c) 48
1. Conduct or participation in the affairs of the enterprise 48

2. Conduct or participation in a pattern of racketeering activity 49
G. Requested Relief 49
VII FOURTH CLAIM FOR RELIEF (Violations of Nevada Racketeering Laws) 50
A. General Allegations 50
B. Racketeering Activities 52
1. Nev. Rev. Stat. § 205.380 52
2. Nev. Rev. Stat. § 686A.291(1) 55
3. Nev. Rev. Stat. § 686A.291(2) 56
4. Nev. Rev. Stat. § 686A.291(3) 59
C. The RICO "Enterprise" 60
1. Humana as RICO "Enterprise" but not as RICO "Person" 60
2. Humana Insurance as RICO "Enterprise" but not as RICO "Person" 61
3. The "Humana Group" as RICO "Enterprise" 61
a. Membership of the Humana Group (61);
b. Purposes and Responsibilities of the Humana Group. (61);
c. Bases for the Humana Group (62);
d. Time Period of the Humana Group (63);
e. Culpability of the Humana Group (63)
D. Violations of Nev. Rev. Stat. § 207.400(1)(a)(2) 63
E. Violations of Nev. Rev. Stat. § 207.400(1)(c)(1) 64
F. Violations of Nev. Rev. Stat. § 207.400(1)(c)(2) 64
G. Violations of Nev. Rev. Stat. § 207.400(1)(h) to violate Nev. Rev. Stat. § 207.400(1)(a)(2) 65
H. Violations of Nev. Rev. Stat. § 207.400(1)(h) to violate Nev. Rev. Stat. § 207.400(1)(c)(1) 65
I. Violations of Nev. Rev. Stat. § 207.400(1)(h) to violate Nev. Rev. Stat. § 207.400(1)(c)(2) 66
J. Requested Relief 66
VIII PRAYER FOR RELIEF 67

Plaintiffs Mary Forsyth, Marrietta Cade, Willie Andrews, Mary Lou Buehler, Helen Staves, Randolph Bratton, and Searle Auto Glass, Inc., d/b/a Best Glass Co., by and through their counsel of record, J. Randall Jones and Will Kemp of Jones, Jones, Close & Brown, Chartered; Stanley M. Chesley of Waite, Schneider, Bayless & Chesley Co., L.P.A.; John L. Cummings III of Cummings, Cummings & Dudenhefer; and Wendell Gauthier of Gauthier & Murphy, for their causes of action against Defendants complain, aver, and allege as follows:

I

JURISDICTION AND VENUE

1. This action arises under the laws of the United States and includes claims for relief under 29 U.S.C. § 1001, et seq., the Employment Retirement Income Security Act (''ERISA''); these proceedings are also instituted against the above-named Defendants Humana, Inc. and Humana Health Insurance, Inc. under Sections 4 and 16 of the Clayton Act (15 U.S.C. §§ 15 and 26) to secure damages from and injunctive relief against Humana for its violations of Section 2 of the Sherman Act (15 U.S.C. § 2) as hereinafter alleged; these proceedings are also instituted under 18 U.S.C. §§ 1961 - 1968; these proceedings are also instituted under the law of the State of Nevada. Subject matter jurisdiction is conferred on this Court by 15 U.S.C. §§ 15 & 16, 18 U.S.C. § 1964(c), 28 U.S.C. § 1331, 28 U.S.C. § 1337, 28 U.S.C. § 1367, and 29 U.S.C. § 1132

2. Venue of this action is proper in this Court pursuant to 15 U.S.C. § 15, 18 U.S.C. § 1965, 28 U.S.C. § 1391, and 29 U.S.C. § 1132.

3. Defendants Humana and Humana Insurance maintain offices and transact business and may be found within the District of Nevada. The interstate trade and commerce

involved and affected by the alleged violations of the antitrust laws is carried on, in part, within the District of Nevada. These claims arose within the District of Nevada. It is in the ends of justice that other parties be brought before this Court.

II

RELEVANT TIMES

4. The period of time relevant to this Third Amended Complaint is from 1984 to the present. Within that relevant period, (a) the breaches of fiduciary duties by Defendants Humana Insurance, Wendell Cherry, and William Larry Cash continued from 1984 through at least 1989; (b) Defendants' monopolization or attempts to monopolize have continued from 1984 to the present; (c) Defendants' scheme to defraud and to obtain money by false pretenses continued from 1984 through at least 1989, (d) Defendants' pattern of racketeering activities have continued from 1984 to the present; and (e) the duration of each of the three enterprises described *infra* has continued from 1984 to the present. This Court has limited the period of recovery herein to that for Defendants' acts and events occurring during the period from 1985 through 1988, inclusive.

III

PARTIES

5. Plaintiff Mary Forsyth resides at 4625 East Twain Street, Las Vegas, Nevada 89121. In 1986 Ms. Forsyth was insured with Humana Care Plus through her employer, Kreel Printing. Ms. Forsyth paid a portion of the insurance premiums for her insurance with Defendant Humana Health Insurance of Nevada, Inc. (''Humana Insurance'') through payroll deductions.

6. Plaintiff Marrietta Cade, 4433 West Lake Mead Boulevard, Las Vegas, Nevada has been insured with Humana Insurance since 1985. Marrietta Cade worked for many years at the Las Vegas Sun. Mrs. Cade terminated her employment in December 1988. Mrs. Cade was at all times relevant Humana Insurance insured and currently remains personally insured with Humana Care Plus paying a monthly premium of approximately $355.00 per month. Her husband, Robert Cade, was a dependent under her Humana Insurance policy. Robert Cade was hospitalized at Humana Hospital-Sunrise between October 7, 1987 and October 17, 1987. The Cades incurred a hospital bill of $16,437.66. Mrs. Cade paid co-payments for her husband's hospitalization.

7. Plaintiff Willie Andrews, 804 McWilliams Street, Las Vegas, Nevada 89106, has been insured with Humana Care Plus since May 1985. At all times relevant, Ms. Andrews was employed with the Clark County School District and made premium payments through her employer. Ms. Andrews was hospitalized from November 4, 1986 through November 9, 1986. Pursuant to the 20% co-payment provisions, Ms. Andrews was obligated to pay and did pay a portion of all of her hospitalization costs.

8. Plaintiff Mary Lou Buehler, 210 Myers Avenue, Henderson, Nevada 89015, has been an insured with Humana Insurance since 1984. She is insured through her husband's employer, Cashman Cadillac. Through her husband, a dependent premium was paid of approximately $140.00 per month for her coverage. In September 1987 and again in October of 1988, Mrs. Buehler was hospitalized for a total of approximately fourteen days. Her charges for those hospitalizations were $23,293.94 and $2,736.85, respectively. Pursuant to the co-payment provision of her policy she was obligated to pay 20% of the costs of her hospitalization. Mrs. Buehler has paid a portion of the co-payment.

9. Plaintiff Helen Staves, HCR 65, Box 71408, Pahrump, Nevada 89041, has been insured with Humana Insurance since July 1988. At all times relevant, Ms. Staves was employed at the Dunes Hotel and made separate monthly premium payments of $40.00 per pay period for her policy of health insurance with Humana Insurance. In October 1988 Ms. Staves was hospitalized at Humana Hospital-Sunrise. Pursuant to the co-payment provisions under her policy, she was required to pay 20% of the costs of that hospitalization. Her expenses incurred for that hospitalization were $14,764.35. Ms. Staves paid her portion of the co-payment.

10. Plaintiff Randolph Bratton, P.O. Box 175, State Route 38, Las Vegas, Nevada 89124 has been insured with Humana Insurance since 1985. Between 1985 and August of 1987, Mr. Bratton was employed by the Las Vegas Sun. Since August 1987 Mr. Bratton has been employed by the Clark County School District. At all times relevant, Mr. Bratton was an insured of Humana Insurance. On February 12, 1988, Mr. Bratton was admitted to Humana Hospital-Sunrise. At that time day surgery was performed on Mr. Bratton and he incurred a hospital bill of approximately $1,400.00. Mr. Bratton remains obligated to make the 20% co-payment.

11. Plaintiff Searle Auto Glass, Inc., doing business as Best Glass Co. (''Best Glass''), 1225 S. Commerce Street, Las Vegas, Nevada 89102, is a Nevada corporation in good standing. Best Glass has used Humana Insurance to provide health insurance to its employees between the years 1985 and 1988, inclusive. Best Glass's group number with Humana Insurance was 82801-18351-001. When Best Glass first became an insured with Humana Insurance, its premiums were very reasonable: $64.23 per employee per billing period. In 1986 those premiums increased by 3 percent, and in 1987 by 13 percent. Finally, in 1988, when Best Glass

decided not to renew with Humana Insurance, Humana Insurance sought a premium increase of 41 percent to continue coverage of employees of Best Glass.

12. Defendants did not inform individual Plaintiffs or Best Glass that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those Plaintiffs at Humana-Sunrise.

13. Defendant Humana Health Insurance of Nevada, Inc. (''Humana Insurance'') is a corporation organized and existing under the laws of the State of Nevada with its principal place of business in Las Vegas, Nevada. Humana Insurance is a wholly-owned subsidiary of Humana through Humana's ownership of Group Health Insurance, Inc. (''Group Health''). Humana Insurance markets and sells group health insurance through employee benefit plans to employers throughout the State of Nevada, but with its principal geographic market being the Southern Nevada market, an area that includes portions of Southern California, Arizona, and Utah.

14. Defendant Humana, Inc. (''Humana'') is a corporation organized and existing under the laws of the State of Delaware, with its principal place of business in Louisville, Kentucky. Humana is, and has been for many years, one of the largest owners and operators of acute-care hospitals in the United States. It owned and operated approximately 87 hospitals and health care facilities in 1986, one of which was Humana Hospital-Sunrise (''Humana-Sunrise'') in Las Vegas, Nevada. Although Humana-Sunrise was only one of Humana's 87 hospitals in 1986, according to Humana's 1986 report to stockholders, Humana-Sunrise generated 6.6 percent of Humana's gross revenue; and according to documents filed with the Nevada Department of Humana Resources in 1986, Humana-Sunrise generated 38 percent of Humana's pretax profits.

15. Defendant Wendell Cherry was at all times relevant to this litigation a resident of Kentucky. Cherry was one of the two co-founders of Humana, Inc. During the years 1984 through 1989, Cherry was the President and Chief Operating Officer of Humana, Inc., a member of the Executive Committee of Humana, Inc., a director of both Humana, Inc. and Humana Insurance, and a principal stockholder of Humana, Inc. Cherry died on or about July 16, 1991. First Kentucky Trust Co. has been duly appointed as administrator of the estate of Wendell Cherry. Defendant William Cherry and Defendant First Kentucky Trust Co., in its capacity as the administrator of the estate of Wendell Cherry, are hereinafter referred to collectively as ''Wendell Cherry'' or ''Cherry.''

16. Defendant William Larry Cash is and was at all times relevant to this litigation a resident of Kentucky. Cash is and has been an employee of Humana, Inc. and/or Humana Insurance since at least 1973. During the period from 1983 through 1989 Cash held the position at first of Vice President of Finance and Controller, Group Health Division, Humana, Inc., and later of Senior Vice President of Finance, Group Health Division, Humana, Inc. From 1984 through at least 1989 Cash held the position of Vice President of Humana Insurance. From 1986 through at least 1989 Cash was a director of Humana insurance.

17. The true names and capacities, whether individual, corporate, associate, or otherwise, of Defendants herein designated as DOES I through X, inclusive, are not known to Plaintiffs at this time, who therefore sue those Defendants by fictitious names. Each of those Defendants is responsible in some manner for the events and happenings and proximately caused the injuries and damages herein alleged. Plaintiffs will request leave to amend this Complaint to allege the true names and capacities of those Defendants when and as Plaintiffs ascertain them.

18. By order of this Court on September 26, 1989, Plaintiffs Willie Andrews, Randolph Bratton, Marrietta Cade, Mary Lou Buehler, and Helen Staves (the "Co-Payor Class") were recognized as class representatives pursuant to Fed. R. Civ. P. 23(b)(3). This class consists of individuals who incurred charges at Humana-Sunrise and who overpaid some portion of their co-payments during the relevant times.

19. By order of this Court on September 26, 1989, certain Plaintiffs (the "Antitrust Premium-Payor Class") were recognized as class representatives pursuant to Fed. R. Civ. P. 23(b)(3). This class consists of individuals or entities who paid all or a portion of the Humana Insurance premiums during the relevant times.

20. By order of this Court on July 9, 1991, Plaintiffs Mary Forsyth, Marrietta Cade, Willie Andrews, Helen Staves, and Best Glass (the "Antitrust Co-Payor Class") were recognized as class representatives pursuant to Fed. R. Civ. P. 23(b)(3). This class consists of individuals who incurred charges at Humana-Sunrise and who overpaid some portion of their co-payments during the relevant times.

21. By order of this Court on July 9, 1991, Plaintiffs Mary Forsyth, Marrietta Cade, Willie Andrews, Mary Lou Buehler, Helen Staves, Randolph Bratton, and Best Glass (the "RICO Premium-Payor Class") were recognized as class representatives pursuant to Fed. R. Civ. P. 23(b)(3). This class consists of individuals or entities who paid all or a portion of the Humana Insurance premiums during the relevant times.

22. By order of this Court on July 9, 1991, Plaintiffs Marietta Cade, Willie Andrews, Mary Lou Buehler, Helen Staves, and Randolph Bratton (the "RICO Co-Payor Class") were recognized as class representatives pursuant to Fed. R. Civ. P. 23(b)(3). This class consists of individuals who incurred charges at Humana-Sunrise and who overpaid some portion of their co-payments during the relevant times.

CLASS ACTION

IV

FIRST CLAIM FOR RELIEF

(Violations of ERISA)

23. The Co-Payor Class reasserts and realleges each and every allegation contained in paragraphs 1 through 22 of this Third Amended Complaint as though fully set forth at this point.

24. The Co-Payor Class consists of employees obtaining health insurance benefits under an employee benefit plan as defined under 29 U.S.C. 1001, et seq.

25. The members of the Co-Payor Class incurred charges at Humana-Sunrise for hospitalization and were obligated to or did pay a portion of the hospital charges. Defendant Humana Insurance was the insurer of the members of the Co-Payor Class through its group health insurance plan, Humana Care Plus.

A. Negotiation of the Secret Discount

26. On or about April 24, 1984, Humana and Humana Insurance negotiated a secret agreement that greatly reduced or discounted hospital charges for Humana Insurance patients incurring charges at Humana-Sunrise. Humana Insurance thereby exercised discretionary authority and discretionary control respecting management of the group health insurance plan, discretionary authority and discretionary control respecting management or disposition of assets of the plan, and discretionary authority or discretionary responsibility in the administration of the plan. Consequently Humana Insurance was a fiduciary as defined under 29 U.S.C. § 1001(21)(A).

27. The aforementioned secret agreement between Humana and Humana Insurance specifically provided that

Humana-Sunrise agreed to accept as payment in full for treatment of insureds at Humana-Sunrise amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services.

1. Involvement of Wendell Cherry.

28. Defendant Wendell Cherry was the President and Chief Operating Officer of Humana on April 24, 1984 when Humana and Humana Insurance executed the aforementioned secret agreement.

29. Defendant Wendell Cherry was the President of Humana Insurance on April 24, 1984 when Humana and Humana Insurance executed the aforementioned secret agreement.

30. Defendant Wendell Cherry was a director of Humana on April 24, 1984 when Humana and Humana Insurance executed the aforementioned secret agreement.

31. Defendant Wendell Cherry was a director of Humana Insurance on April 24, 1984 when Humana and Humana Insurance executed the aforementioned secret agreement.

32. Defendant Wendell Cherry was aware of the contents of the aforementioned secret agreement and of the provisions contained therein. Cherry authorized and approved those contents. Cherry thereby exercised discretionary authority and discretionary control respecting management of the group health insurance plan, discretionary authority and discretionary control respecting management or disposition of assets of the plan, and discretionary authority or discretionary responsibility in the administration of the plan. Consequently Cherry was a fiduciary as defined under 29 U.S.C. § 1001(21)(A).

2. Involvement of William Larry Cash

33. Defendant William Larry Cash was a Vice President and the Controller of Humana on April 24, 1984 when Humana and Humana Insurance executed the aforementioned secret agreement.

34. Defendant William Larry Cash was a Vice President of Humana Insurance on April 24, 1984 when Humana and Humana Insurance executed the aforementioned secret agreement.

35. Defendant William Larry Cash was a signator to the aforementioned secret agreement, representing Humana Insurance, and therefore Cash was aware of the contents of that agreement. Accordingly Cash authorized and approved the contents of that agreement. Cash thereby exercised discretionary authority and discretionary control respecting management of the group health insurance plan, discretionary authority and discretionary control respecting management or disposition of assets of the plan, and discretionary authority or discretionary responsibility in the administration of the plan. Consequently Cash was a fiduciary as defined under 29 U.S.C. § 1001(21)(A).

B. Concealment of the Secret Discount

36. During the years 1985 and 1986 Humana Insurance actively concealed from Plaintiffs that Humana-Sunrise had agreed to accept as payment in full for treatment of those insureds at Humana-Sunrise amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

1. Involvement of Wendell Cherry

37. Defendant Wendell Cherry was the President and Chief Operating Officer of Humana during the years 1985 and 1986 when Humana Insurance actively concealed from Plaintiffs that Humana-Sunrise had agreed to accept as payment in full for treatment of insureds at Humana-Sunrise amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

38. Defendant Wendell Cherry was a director of Humana during the years 1985 and 1986 when Humana Insurance actively concealed from Plaintiffs that Humana-Sunrise had agreed to accept as payment in full for treatment of insureds at Humana-Sunrise amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

39. Defendant Wendell Cherry was a director of Humana Insurance during the years 1985 and 1986 when Humana Insurance actively concealed from Plaintiffs that Humana-Sunrise had agreed to accept as payment in full for treatment at Humana-Sunrise of persons insured by Humana Insurance at Humana-Sunrise amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or

discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

2. Involvement of William Larry Cash

40. Defendant William Larry Cash was a Vice President and the Controller of Humana during the years 1985 and 1986 when Humana Insurance actively concealed from Plaintiffs that Humana-Sunrise had agreed to accept as payment in full for treatment at Humana-Sunrise of persons insured by Humana Insurance at Humana-Sunrise amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

41. Defendant William Larry Cash was a Vice President of Humana Insurance during the years 1985 and 1986 when Humana Insurance actively concealed from Plaintiffs that Humana-Sunrise had agreed to accept as payment in full for treatment at Humana-Sunrise of persons insured by Humana Insurance at Humana-Sunrise amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

42. Defendant William Larry Cash was a director of Humana Insurance during the year 1986 when Humana

Insurance actively concealed from Plaintiffs that Humana-Sunrise had agreed to accept as payment in full for treatment at Humana-Sunrise of persons insured by Humana Insurance at Humana-Sunrise amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

C. Failure to Disclose the Secret Discount

43. During the years 1985 and 1986 Humana Insurance, Wendell Cherry, and William Larry Cash failed to disclose to Plaintiffs, and failed to take any action to inform Plaintiffs, that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

1. Involvement of Wendell Cherry

44. Defendant Wendell Cherry was the President and Chief Operating Officer of Humana during the years 1985 and 1986 when Humana Insurance and Cherry failed to disclose to Plaintiffs, and failed to take any action to inform Plaintiffs, that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower

than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

45. Defendant Wendell Cherry was a director of Humana during the years 1985 and 1986 when Humana Insurance and Cherry failed to disclose to Plaintiffs, and failed to take any action to inform Plaintiffs, that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

46. Defendant Wendell Cherry was a director of Humana Insurance during the years 1985 and 1986 when Humana Insurance and Cherry failed to disclose to Plaintiffs, and failed to take any action to inform Plaintiffs, that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

2. Involvement of William Larry Cash

47. Defendant William Larry Cash was a Vice President and the Controller of Humana during the years 1985 and 1986 when Humana Insurance and Cash failed to disclose to Plaintiffs, and failed to take any action to inform Plaintiffs, that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

48. Defendant William Larry Cash was a Vice President of Humana Insurance during the years 1985 and 1986 when Humana Insurance and Cash failed to disclose to Plaintiffs, and failed to take any action to inform Plaintiffs, that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

49. Defendant William Larry Cash was a director of Humana Insurance during the year 1986 when Humana Insurance and Cash failed to disclose to Plaintiffs, and failed to take any action to inform Plaintiffs, that Humana-Sunrise had agreed to accept as payment in full, for treatment at

Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

D. Submission of the Fraudulent Master Policy

50. In 1984 Humana Insurance submitted for approval to the Insurance Division of Nevada a master policy of group health insurance. That master policy set forth terms, conditions, and representations that were to appear in all policies of group health insurance that Humana Insurance sought to market in Nevada, and was approved for that purpose by the Insurance Division of Nevada.

51. The aforementioned master policy, and the Humana Care Plus policies that conformed thereto, failed to disclose to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to those insureds the savings that Humana Insurance obtained by negotiating a discount on those charges.

52. The Humana Care Plus policies required that each member of the Co-Payor Class pay 20% of the charges for medical treatment at Humana-Sunrise. Humana Insurance agreed to pay the remaining 80% of those charges. The members of the Co-Payor Class believed, and their

agreements with Humana Insurance provided, that the members of the Co-Payor Class and Humana Insurance would be paying their respective contractual percentages of the charges.

1. Involvement of Wendell Cherry

53. Defendant Wendell Cherry was the President and Chief Operating Officer of Humana in 1984 on the date when Humana Insurance submitted for approval the aforementioned master policy.

54. Defendant Wendell Cherry was the President of Humana Insurance in 1984 on the date when Humana Insurance submitted for approval the aforementioned master policy.

55. Defendant Wendell Cherry was a director of Humana in 1984 on the date when Humana Insurance submitted for approval the aforementioned master policy.

56. Defendant Wendell Cherry was a director of Humana Insurance in 1984 on the date when Humana Insurance submitted for approval the aforementioned master policy.

57. Defendant Wendell Cherry was a signator to the aforementioned master policy, and therefore Cherry was aware of the contents of that master policy and of the Humana Care Plus policies that conformed thereto. Accordingly Cherry authorized and approved the contents of that master policy and of the Humana Health Plus policies that conformed thereto.

2. Involvement of William Larry Cash

58. Defendant William Larry Cash was a Vice President and the Controller of Humana in 1984 on the date when Humana Insurance submitted for approval the aforementioned master policy.

59. Defendant William Larry Cash was a Vice President of Humana Insurance in 1984 on the date when Humana Insurance submitted for approval the aforementioned master policy.

E. Sale of the Fraudulent Group Policies

60. During the period from 1984 through 1988 Defendant Humana Insurance sold policies of group health insurance that conformed to the aforementioned master policy.

1. Involvement of Wendell Cherry

61. Defendant Wendell Cherry was the President and Chief Operating Officer of Humana during the period from 1984 through 1988 when Defendant Humana Insurance sold policies of group health insurance that conformed to the aforementioned master policy.

62. Defendant Wendell Cherry was President of Humana Insurance during a portion of the period from 1984 through 1988 when Defendant Humana Insurance sold policies of group health insurance that conformed to the aforementioned master policy.

63. Defendant Wendell Cherry was a director of Humana during the period from 1984 through 1988 when Defendant Humana Insurance sold policies of group health insurance that conformed to the aforementioned master policy.

64. Defendant Wendell Cherry was a director of Humana Insurance during the period from 1984 through 1988 when Defendant Humana Insurance sold policies of group health insurance that conformed to the aforementioned master policy.

2. Involvement of William Larry Cash

65. Defendant William Larry Cash was a Vice President or Senior Vice President and the Controller of Humana

during the period from 1984 through 1988 when Defendant Humana Insurance sold policies of group health insurance that conformed to the aforementioned master policy.

66. Defendant William Larry Cash was a Vice President of Humana Insurance during the period from 1984 through 1988 when Defendant Humana Insurance sold policies of group health insurance that conformed to the aforementioned master policy.

67. Defendant William Larry Cash was a director of Humana Insurance during a portion of the period from 1984 through 1988 when Defendant Humana Insurance sold policies of group health insurance that conformed to the aforementioned master policy.

68. Defendant William Larry Cash was a signator, on behalf of Humana Insurance, to some or all of the Humana Care Plus policies that contained the same terms, conditions, and representations as those set forth in the aforementioned master policy, and therefore Cash was aware of the contents of that master policy and of the Humana Care Plus policies that conformed thereto. Accordingly Cash authorized and approved the contents of those Humana Care Plus policies.

F. Promotion of the Fraudulent Group Policies

69. Humana Insurance advertised its policies of group health insurance during the period from 1984 through 1988 and stated in those advertisements that Humana Insurance had reduced the costs of providing medical treatment and was passing along those savings to its insureds. In those advertisements Humana Insurance did not inform insureds that Humana Insurance was not passing along to them the savings it obtained by negotiating a discount on the charges for treatment of those insureds at Humana-Sunrise.

70. Humana Insurance sales personnel did not inform insureds that Humana Insurance was not passing along to

them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those insureds at Humana-Sunrise.

1. Involvement of Wendell Cherry

71. Defendant Wendell Cherry was the President and Chief Operating Officer of Humana during the period from 1984 through 1988 when Humana Insurance's advertisements and sales personnel did not inform insureds that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those insureds at Humana-Sunrise.

72. Defendant Wendell Cherry was the President of Humana Insurance during a portion of the period from 1984 through 1988 when Humana Insurance's advertisements and sales personnel did not inform insureds that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those insureds at Humana-Sunrise.

73. Defendant Wendell Cherry was a director of Humana during the period from 1984 through 1988 when Humana Insurance's advertisements and sales personnel did not inform insureds that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those insureds at Humana-Sunrise.

74. Defendant Wendell Cherry was a director of Humana Insurance during the period from 1984 through 1988 when Humana Insurance's advertisements and sales personnel did not inform insureds that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those insureds at Humana-Sunrise.

2. Involvement of William Larry Cash

75. Defendant William Larry Cash was a Vice President or Senior Vice President and the Controller of Humana during the period from 1984 through 1988 when Humana Insurance's advertisements and sales personnel did not inform insureds that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those insureds at Humana-Sunrise.

76. Defendant William Larry Cash was a Vice President of Humana Insurance during the period from 1984 through 1988 when Humana Insurance's advertisements and sales personnel did not inform insureds that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those insureds at Humana-Sunrise.

77. Defendant William Larry Cash was a director of Humana Insurance during a portion of the period from 1984 through 1988 when Humana Insurance's advertisements and sales personnel did not inform insureds that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those insureds at Humana-Sunrise.

G. Failure to Pass Along Reduced Costs or Discounts

78. Defendants Humana Insurance, Wendell Cherry, and William Larry Cash breached their fiduciary duties to all members of the Co-Payor Class during the period from 1984 through 1988 in they failed to pass along to insureds, in the form of reduced co-payments, the reduced costs or discounts that Humana Insurance was able to negotiate with Humana, in violation of 29 U.S.C. § 1004.

1. Involvement of Wendell Cherry

79. Defendant Wendell Cherry was the President and Chief Operating Officer of Humana during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class in that he failed to pass along to insureds, in the form of reduced co-payments, the reduced costs or discounts that Humana Insurance was able to negotiate with Humana, in violation of 29 U.S.C. § 1004.

80. Defendant Wendell Cherry was the President of Humana Insurance during a portion of the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class in that he failed to pass along to insureds, in the form of reduced co-payments, the reduced costs or discounts that Humana Insurance was able to negotiate with Humana, in violation of 29 U.S.C. § 1004.

81. Defendant Wendell Cherry was a director of Humana during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class in that he failed to pass along to insureds, in the form of reduced co-payments, the reduced costs or discounts that Humana Insurance was able to negotiate with Humana, in violation of 29 U.S.C. § 1004.

82. Defendant Wendell Cherry was a director of Humana Insurance during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class in that he failed to pass along to insureds, in the form of reduced co-payments, the reduced costs or discounts that Humana Insurance was able to negotiate with Humana, in violation of 29 U.S.C. § 1004.

2. Involvement of William Larry Cash

83. Defendant William Larry Cash was a Vice President or Senior Vice President and the Controller of Humana

during the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class in that he failed to pass along to insureds, in the form of reduced co-payments, the reduced costs or discounts that Humana Insurance was able to negotiate with Humana, in violation of 29 U.S.C. § 1004.

84. Defendant William Larry Cash was a Vice President of Humana Insurance during the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class in that he failed to pass along to insureds, in the form of reduced co-payments, the reduced costs or discounts that Humana Insurance was able to negotiate with Humana, in violation of 29 U.S.C. § 1004.

85. Defendant William Larry Cash was a director of Humana Insurance during a portion of the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class in that he failed to pass along to insureds, in the form of reduced co-payments, the reduced costs or discounts that Humana Insurance was able to negotiate with Humana, in violation of 29 U.S.C. § 1004.

H. Failure to Accomplish Exclusive Purpose of Providing Benefits and Defraying Costs of Administration

86. Defendants Humana Insurance, Wendell Cherry, and William Larry Cash breached their fiduciary duties to all members of the Co-Payor Class during the period from 1984 through 1988 by failing to accomplish the exclusive purpose of providing benefits to participants and by failing to defray the reasonable expenses necessary for the administration of the plan. Humana Insurance imprudently decided to retain the co-payment refunds that Humana Insurance negotiated with Humana. Humana Insurance received excessive compensation in violation of its fiduciary duties pursuant to 29 U.S.C. § 1104.

1. Involvement of Wendell Cherry

87. Defendant Wendell Cherry was the President and Chief Operating Officer of Humana during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by failing to accomplish the exclusive purpose of providing benefits to participants, by failing to defray the reasonable expenses necessary for the administration of the plan, and by allowing Humana Insurance to receive excessive compensation.

88. Defendant Wendell Cherry was the President of Humana Insurance during a portion of the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by failing to accomplish the exclusive purpose of providing benefits to participants, by failing to defray the reasonable expenses necessary for the administration of the plan, and by allowing Humana Insurance to receive excessive compensation.

89. Defendant Wendell Cherry was a director of Humana during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by failing to accomplish the exclusive purpose of providing benefits to participants, by failing to defray the reasonable expenses necessary for the administration of the plan, and by allowing Humana Insurance to receive excessive compensation.

90. Defendant Wendell Cherry was a director of Humana Insurance during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by failing to accomplish the exclusive purpose of providing benefits to participants, by failing to defray the reasonable expenses necessary for the administration of the plan, and by allowing Humana Insurance to receive excessive compensation.

2. Involvement of William Larry Cash

91. Defendant William Larry Cash was a Vice President or Senior Vice President and the Controller of Humana during the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by failing to accomplish the exclusive purpose of providing benefits to participants, by failing to defray the reasonable expenses necessary for the administration of the plan, and by allowing Humana Insurance to receive excessive compensation.

92. Defendant William Larry Cash was a Vice President of Humana Insurance during the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by failing to accomplish the exclusive purpose of providing benefits to participants, by failing to defray the reasonable expenses necessary for the administration of the plan, and by allowing Humana Insurance to receive excessive compensation.

93. Defendant William Larry Cash was a director of Humana Insurance during a portion of the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by failing to accomplish the exclusive purpose of providing benefits to participants, by failing to defray the reasonable expenses necessary for the administration of the plan, and by allowing Humana Insurance to receive excessive compensation.

I. Failure to Adhere to Documents and Instruments Governing the Plan

94. Defendants Humana Insurance, Wendell Cherry, and William Larry Cash breached their fiduciary duties to all members of the Co-Payor Class during the period from 1984 through 1988 by failing to adhere to the documents and instruments governing the plan, including without limitation Nevada Assembly Bills 278 and 289, and 29 U.S.C. § 1104.

1. Involvement of Wendell Cherry

95. Defendant Wendell Cherry was the President and Chief Operating Officer of Humana during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by failing to adhere to the documents and instruments governing the plan, including without limitation Nevada Assembly Bills 278 and AB 289, and 29 U.S.C. § 1104.

96. Defendant Wendell Cherry was the President of Humana Insurance during a portion of the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by failing to adhere to the documents and instruments governing the plan, including without limitation Nevada Assembly Bills 278 and AB 289, and 29 U.S.C. § 1104.

97. Defendant Wendell Cherry was a director of Humana during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by failing to adhere to the documents and instruments governing the plan, including without limitation Nevada Assembly Bills 278 and AB 289, and 29 U.S.C. § 1104.

98. Defendant Wendell Cherry was a director of Humana Insurance during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by failing to adhere to the documents and instruments governing the plan, including without limitation Nevada Assembly Bills 278 and AB 289, and 29 U.S.C. § 1104.

2. Involvement of William Larry Cash

99. Defendant William Larry Cash was a Vice President or Senior Vice President and the Controller of Humana during the period from 1984 through 1988 when Cash

breached his fiduciary duties to all members of the Co-Payor Class by failing to adhere to the documents and instruments governing the plan, including without limitation Nevada Assembly Bills 278 and AB 289, and 29 U.S.C. § 1104.

100. Defendant William Larry Cash was a Vice President of Humana Insurance during the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by failing to adhere to the documents and instruments governing the plan, including without limitation Nevada Assembly Bills 278 and AB 289, and 29 U.S.C. § 1104.

101. Defendant William Larry Cash was a director of Humana Insurance during a portion of the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by failing to adhere to the documents and instruments governing the plan, including without limitation Nevada Assembly Bills 278 and AB 289, and 29 U.S.C. § 1104

J. Failure to Discharge Duties With Diligence and Care

102. Defendants Humana Insurance, Wendell Cherry, and William Larry Cash breached their fiduciary duties to all members of the Co-Payor Class during the period from 1984 through 1988 by failing to discharge those duties with respect to the plan with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use the conduct of an enterprise of a like character and with like aims.

1. Involvement of Wendell Cherry

103. Defendant Wendell Cherry was the President and Chief Operating Officer of Humana during the period from 1984 through 1988 when Cherry breached his fiduciary

duties to all members of the Co-Payor Class by failing to discharge those duties with respect to the plan with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

104. Defendant Wendell Cherry was the President of Humana Insurance during a portion of the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by failing to discharge those duties with respect to the plan with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

105. Defendant Wendell Cherry was a director of Humana during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by failing to discharge those duties with respect to the plan with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

106. Defendant Wendell Cherry was a director of Humana Insurance during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by failing to discharge those duties with respect to the plan with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

2. Involvement of William Larry Cash

107. Defendant William Larry Cash was a Vice President or Senior Vice President and the Controller of Humana during the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by failing to discharge those duties with respect to the plan with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would have used in the conduct of an enterprise of a like character and with like aims.

108. Defendant William Larry Cash was a Vice President of Humana Insurance during the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by failing to discharge those duties with respect to the plan with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would have used in the conduct of an enterprise of a like character and with like aims.

109. Defendant William Larry Cash was a director of Humana Insurance during a portion of the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by failing to discharge those duties with respect to the plan with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would have used in the conduct of an enterprise of a like character and with like aims.

K. Dealing in a Fiduciary's Self-Interest

110. Defendants Humana Insurance, Wendell Cherry, and William Larry Cash engaged in prohibited transactions in violation of their fiduciary duties during the period from

1984 through 1988 by dealing with the assets of the plan in Humana Insurance's own interest or for its own account, in violation of 29 U.S.C. § 1106.

1. Involvement of Wendell Cherry

111. Defendant Wendell Cherry was the President and Chief Operating Officer of Humana during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by engaging in prohibited transactions by dealing with the assets of the plan in Humana Insurance's own interest or for its own account, in violation of 29 U.S.C. § 1106.

112. Defendant Wendell Cherry was the President of Humana Insurance during a portion of the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by engaging in prohibited transactions by dealing with the assets of the plan in Humana Insurance's own interest or for its own account, in violation of 29 U.S.C. § 1106.

113. Defendant Wendell Cherry was a director of Humana during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by engaging in prohibited transactions by dealing with the assets of the plan in Humana Insurance's own interest or for its own account, in violation of 29 U.S.C. § 1106.

114. Defendant Wendell Cherry was a director of Humana insurance during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by engaging in prohibited transactions by dealing with the assets of the plan in Humana Insurance's own interest or for its own account, in violation of 29 U.S.C. § 1106.

2. Involvement of William Larry Cash

115. Defendant William Larry Cash was a Vice President or Senior Vice President and the Controller of Humana during the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by dealing with the assets of the plan in Humana Insurance's own interest or for its own account, in violation of 29 U.S.C. § 1106.

116. Defendant William Larry Cash was a Vice President of Humana Insurance during the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by dealing with the assets of the plan in Humana Insurance's own interest or for its own account, in violation of 29 U.S.C. § 1106.

117. Defendant William Larry Cash was a director of Humana Insurance during a portion of the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by dealing with the assets of the plan in Humana Insurance's own interest or for its own account, in violation of 29 U.S.C. § 1106.

L. Acting on Behalf of an Adverse Party

118. Defendants Humana Insurance, Wendell Cherry, and William Larry Cash engaged in prohibited transactions in violation of their fiduciary duties during the period from 1984 through 1988 by acting on behalf of Humana, whose interests are adverse to the interests of the plan or the Co-Payor Class. Humana Insurance was prohibited from even negotiating the co-payment amount with its related entity Humana, in violation of 29 U.S.C. § 1106.

1. Involvement of Wendell Cherry

119. Defendant Wendell Cherry was the President and Chief Operating Officer of Humana during the period from

1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by engaging in prohibited transactions by acting on behalf of Humana, whose interests are adverse to the interests of the plan or the Co-Payor Class. Cherry was prohibited from even negotiating the co-payment amount with its related entity Humana, in violation of 29 U.S.C. § 1106.

120. Defendant Wendell Cherry was the President of Humana Insurance during a portion of the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by engaging in prohibited transactions by acting on behalf of Humana, whose interests are adverse to the interests of the plan or the Co-Payor Class. Cherry was prohibited from even negotiating the co-payment amount with its related entity Humana, in violation of 29 U.S.C. § 1106.

121. Defendant Wendell Cherry was a director of Humana during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by engaging in prohibited transactions by acting on behalf of Humana, whose interests are adverse to the interests of the plan or the Co-Payor Class. Cherry was prohibited from even negotiating the co-payment amount with its related entity Humana, in violation of 29 U.S.C. § 1106.

122. Defendant Wendell Cherry was a director of Humana Insurance during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by engaging in prohibited transactions by acting on behalf of Humana, whose interests are adverse to the interests of the plan or the Co-Payor Class. Cherry was prohibited from even negotiating the co-payment amount with its related entity Humana, in violation of 29 U.S.C. § 1106.

2. Involvement of William Larry Cash

123. Defendant William Larry Cash was a Vice President or Senior Vice President and the Controller of Humana during the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by engaging in prohibited transactions by acting on behalf of Humana, whose interests are adverse to the interests of the plan or the Co-Payor Class. Cash was prohibited from even negotiating the co-payment amount with Humana Insurance's related entity Humana, in violation of 29 U.S.C. § 1106.

124. Defendant William Larry Cash was a Vice President of Humana Insurance during the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by engaging in prohibited transactions by acting on behalf of Humana, whose interests are adverse to the interests of the plan or the Co-Payor Class. Cash was prohibited from even negotiating the co-payment amount with Humana Insurance's related entity Humana, in violation of 29 U.S.C. § 1106.

125. Defendant William Larry Cash was a director of Humana Insurance during a portion of the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by engaging in prohibited transactions by acting on behalf of Humana, whose interests are adverse to the interests of the plan or the Co-Payor Class. Cash was prohibited from even negotiating the co-payment amount with Humana Insurance's related entity Humana, in violation of 29 U.S.C. § 1106.

M. Receiving Consideration for a Fiduciary's Own Account

126. Defendants Humana Insurance, Wendell Cherry, and William Larry Cash engaged in prohibited transactions in violation of their fiduciary duties during the period from

1984 through 1988 by unlawfully receiving consideration for Humana Insurance's own personal account in connection with a transaction involving the assets of the plan, in violation of 29 U.S.C. § 1106.

1. Involvement of Wendell Cherry

127. Defendant Wendell Cherry was the President and Chief Operating Officer of Humana during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by unlawfully receiving consideration for Humana Insurance's own personal account in connection with a transaction involving the assets of the plan, in violation of 29 U.S.C. § 1106.

128. Defendant Wendell Cherry was the President of Humana Insurance during a portion of the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by unlawfully receiving consideration for Humana Insurance's own personal account in connection with a transaction involving the assets of the plan, in violation of 29 U.S.C. § 1106.

129. Defendant Wendell Cherry was a director of Humana during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by unlawfully receiving consideration for Humana Insurance's own personal account in connection with a transaction involving the assets of the plan, in violation of 29 U.S.C. § 1106.

130. Defendant Wendell Cherry was a director of Humana Insurance during the period from 1984 through 1988 when Cherry breached his fiduciary duties to all members of the Co-Payor Class by unlawfully receiving consideration for Humana Insurance's own personal account in connection with a transaction involving the assets of the plan, in violation of 29 U.S.C. § 1106.

2. Involvement of William Larry Cash

131. Defendant William Larry Cash was a Vice President or Senior Vice President and the Controller of Humana during the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by unlawfully receiving consideration for Humana Insurance's own personal account in connection with a transaction involving the assets of the plan, in violation of 29 U.S.C. § 1106.

132. Defendant William Larry Cash was a Vice President of Humana Insurance during the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by unlawfully receiving consideration for Humana Insurance's own personal account in connection with a transaction involving the assets of the plan, in violation of 29 U.S.C. § 1106.

133. Defendant William Larry Cash was a director of Humana Insurance during a portion of the period from 1984 through 1988 when Cash breached his fiduciary duties to all members of the Co-Payor Class by unlawfully receiving consideration for Humana Insurance's own personal account in connection with a transaction involving the assets of the plan, in violation of 29 U.S.C. § 1106.

N. Requested Relief

134. It would be wrongful for Humana Insurance to retain monies, in excess of those it might otherwise have been entitled to, when such monies have been obtained wrongfully and in breach of the duties of Humana Insurance, Wendell Cherry, and William Larry Cash to the Co-Payor Class and of Human Insurance's agreement with the Co-Payor Class.

135. A constructive trust should be imposed on Defendants that requires surrender of all monies obtained through the scheme described herein.

136. Plaintiffs should be named the beneficiaries of the constructive trust awarded by this Court.

137. As a result of Defendants' unlawful and/or inequitable scheme heretofore alleged, Plaintiffs have conferred a monetary benefit on Defendant Humana Insurance. Defendant Humana Insurance appreciated and realized the monetary benefit and accepted and retained the monetary benefit under circumstances such that it would be inequitable for Humana Insurance to retain the monetary benefit without returning the benefit to the Co-Payor Class. As a result of the scheme, Defendant Humana Insurance was unjustly enriched, all to the detriment of the Co-Payor Class.

138. The acts and practices of Defendants as set forth and described herein are reasonably likely to continue in the future and cause further injury and damage to Plaintiffs unless restrained by order of this Court, and therefore the Co-Payor Class is entitled to a permanent injunction against Humana Insurance.

139. The Co-Payor Class has been damaged as a result of the breach of ERISA fiduciary duties by Humana Insurance, Wendell Cherry, and William Larry Cash, and it is estimated that the approximate actual damages are in excess of $84,520,143.00.

140. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered; Waite, Schneider, Bayless & Chesley Co., L.P.A.; Cummings, Cummings & Dudenhefer; and Gauthier & Murphy to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor. 29 U.S.C. § 1132(g).

V

SECOND CLAIM FOR RELIEF

(Violations of Federal Antitrust Laws)

141. Plaintiffs reassert and reallege each and every allegation contained in paragraphs 1 through 140 of this Third Amended Complaint as though fully set forth at this point.

142. The Antitrust Premium-Payer Class consists of individuals or entities paying all or a portion of the Humana Insurance premiums during the period from 1985 through 1988, including without limitation employers who made insurance premium payments on behalf of their employees, as well as individual employees who either directly paid insurance premiums on behalf of their dependents, or who did so indirectly by such means as payroll deductions by their employers.

143. Defendant Humana is in the business of owning and operating for-profit acute-care health facilities. Humana owns and operates a for-profit acute-care health care facility named Humana Hospital-Sunrise which provides hospital services in Las Vegas, Nevada.

144. Defendant Humana is also in the business of owning and operating group health care insurance companies, and in 1984 established one such company, Humana Insurance, with its principal place of business in Nevada.

145. The relevant geographic market for antitrust purposes is Clark County, Nevada or a portion thereof.

146. The relevant product market affected by Defendants' conduct is the sale of general, non-specialty, for-profit, acute-care hospital services or a portion thereof, and the group health insurance or health care financing market or a portion thereof.

147. Humana-Sunrise has possessed and exercised market power in the relevant geographic market during the class period. One indication of Humana-Sunrise's market power is its ability consistently to generate profit levels far above competitive levels found in comparable geographic markets, or as compared to national averages, or as compared to Humana hospitals located in other states. In addition to exercising this power within the market for the sale of general, non-specialty, for-profit, acute-care hospital services, the market power of Humana-Sunrise is heightened within relevant submarkets that may include only privately-owned hospitals, or other submarkets that focus on particular hospital products or services, especially as those products or services are obtained by private insureds.

148. Since at least 1984, and to and including the date of the filing of this Complaint, Humana and Humana Insurance have violated Section 2 of the Sherman Act (15 U.S.C. § 2) by monopolizing and attempting to monopolize the above-described markets and/or submarkets.

149. In furtherance of the aforesaid monopolization and attempt to monopolize, Defendants formed a symbiotic relationship between Humana-Sunrise and Humana Insurance, with Humana Insurance acting as a feeder mechanism to funnel Humana Insurance insureds into Humana-Sunrise, where those insureds became members of the Antitrust Co-Payor Class. Defendants established and maintained that relationship with the express purpose and effect of maintaining or enhancing the market power of Humana-Sunrise.

150. Humana and Humana Insurance engaged in a scheme that consisted of numerous actions, the primary purpose and effect of which was to maintain or enhance the market power of Humana-Sunrise.

151. As part of the aforementioned scheme, Humana-Sunrise Hospital and Humana Insurance entered into a secret discount arrangement. Humana and Humana Insurance did not offer that discount arrangement to other insurance companies or to other general, non-specialty, for-profit, acute-care hospitals in the relevant geographic market, did not include Humana Insurance co-payers in that discount arrangement, and did not pass along to Humana Insurance co-payors the savings that Humana Insurance obtained from that discount arrangement. That discount arrangement additionally allowed Humana-Sunrise to conceal illegal profits.

152. As part of the aforementioned scheme, Humana and Humana Insurance prepared and disseminated, or caused to be prepared and disseminated, advertisements that stated Humana Insurance was passing along savings to its insureds, yet failed to disclose to those insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Those advertisements conferred an unfair competitive advantage on Defendants.

153. As part of the aforementioned scheme, Humana Insurance sales personnel did not inform insureds that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those Plaintiffs at Humana-Sunrise.

154. As part of the aforementioned scheme, Humana and Humana Insurance hospital engaged in additional actions, including without limitation the following:

A. Defendants promoted the use of services offered by Humana-Sunrise and discouraged the use of services offered by other general, non-specialty, for-profit, acute-care hospitals through Humana Insurance policies, by requiring extensive penalties for insureds who obtained services from general, non-specialty, for-profit, acute-care hospitals other than Humana-Sunrise. Those penalties included without limitation the following:

1. Requiring a different and punitive deductible for obtaining services from general, non-specialty, for-profit, acute-care hospitals other than Humana-Sunrise;

2. Requiring a different and punitive co-payment for obtaining services from general, non-specialty, for-profit, acute-care hospitals other than Humana-Sunrise;

3. Applying a different standard of review when evaluating and paying claims from general, non-specialty, for-profit, acute-care hospitals other than Humana-Sunrise.

B. Humana engaged in a pattern of predatory pricing by offering Humana Insurance an unreasonable discount, while not offering that discount to other group health insurers in the relevant geographic market, nor to members of the Antitrust Co-Payor Class;

C. Humana Insurance required premiums for group health insurance policies that were anti-competitively high in comparison to premiums charged for compara-

ble insurance by other group health care insurers in comparable geographic markets;

D. Humana Insurance initially engaged in predatory pricing within the relevant geographic market by attempting to undercut the premiums required for comparable insurance by other group health insurers in that market.

E. Humana Insurance required premiums for group health insurance policies that were far higher than those that normal actuarial practices would have indicated were reasonable for the percentages and amounts of co-payments of Humana-Sunrise's actual charges that members of the Antitrust Co-Payor Class paid.

155. The aforementioned scheme created misinformation among employers, insureds, and other third-party payers regarding hospital per diem arrangements and maximum potential discounts, thereby blunting competitive forces and allowing Humana-Sunrise to charge higher prices and offer less discounts than it could have without the scheme. In addition, because Humana Insurance misrepresented the risk-sharing provisions of its group health insurance plan, the premiums that Humana Insurance charged were artificially high, notwithstanding that at times those premiums may have been priced nominally lower than the premiums of comparable policies within the Clark County, Nevada area.

156. As a direct and proximate result of Defendants' market position and power, of their specific intent to maintain or enhance that market power, and of their actions to maintain or enhance that market power with a dangerous probability of success, the members of both the Antitrust Premium-Payor Class and the Antitrust Co-Payor Class incurred antitrust injuries and damages. The members of the Antitrust Premium-Payor Class incurred antitrust injuries and damages in that they were required to pay premiums for

Humana Insurance policies that were high in comparison to what competitive rates would have been in the absence of Humana's market power. The members of the Antitrust Co-Payor Class incurred antitrust injuries and damages in that they were required to pay co-payments for Humana-Sunrise services that were high in comparison to what competitive rates would have been in the absence of Humana's market power.

157. Plaintiffs estimate that the approximate actual damages of the Antitrust Premium-Payor Class and the Antitrust Co-Payor Class are in excess of $181,034,570.00, the principal of which is subject to trebling.

158. The anticompetitive acts and practices of Humana and Humana Insurance as set forth and described herein are reasonably likely to continue in the future and to cause further injury and damage to Plaintiffs unless restrained by order of this Court.

VI

THIRD CLAIM FOR RELIEF

(Violations of Federal Racketeering Laws)

A. General Allegations

159. Plaintiffs reassert and reallege each and every allegation contained in paragraphs 1 through 158 of this Third Amended Complaint as though fully set forth at this point.

160. Each Plaintiff and each member of the designated class that Plaintiffs represent is a "person" within the meaning of 18 U.S.C. § 1961(3) and § 1964(c).

161. With respect to their activities alleged herein, Defendants acted at all times with malice, intent, and knowledge, and with a wanton and reckless disregard for the rights of Plaintiffs.

162. With respect to the activities alleged herein, each Defendant aided and abetted each other Defendant, and others not presently known to Plaintiffs, in committing those activities, all in violation of the statutes set forth herein, and specifically in violation of 18 U.S.C. § 2. Each Defendant agreed to the operation of the scheme to defraud and to obtain money by false pretenses.

163. With respect to the activities alleged herein, other than those involving violations of 18 U.S.C. 1962(d), each Defendant conspired with each other Defendant, and with others not presently known to Plaintiffs, in committing those activities, all in violation of the statutes set forth herein, and specifically in violation of 18 U.S.C. § 1962(d). Each Defendant agreed to the conspiracy to defraud and to obtain money by false pretenses.

164. As part of a scheme to defraud Plaintiffs and to obtain money from Plaintiffs by false pretenses, by charging Plaintiffs a different per diem per patient day on their co-payments, Humana and Humana Insurance entered into a secret agreement (the "Agreement") whereby Humana-Sunrise agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and whereby Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services. Humana Insurance did not discount the portion of those charges paid by Plaintiffs but based them instead on the usual and customary rate.

165. Humana Insurance did not reduce premiums in the amount discounted. As a part of the scheme to defraud and to obtain money by false pretenses, Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash used false and fraudulent pretenses, representations, and promises

calculated to deceive persons of ordinary prudence and due care, and concealed and made material nondisclosures of facts and information important to the insureds, including without limitation the existence of the secret agreement and that Humana was billing Humana Insurance at a different per diem, all so as to unlawfully, intentionally, and willfully, and with the intent to defraud, that is, knowingly and with specific intent to deceive in order to cause financial gain to themselves, procure secret profits to the use and benefit of themselves and others and to the detriment of the insureds consisting of the named Plaintiffs, as representatives of a class pursuant to Fed. R. Civ. P. 23.

166. The scheme to defraud and to obtain money by false pretenses evolved over time a pattern of illegal activity that inflicted discrete harms on the insureds and others. The insureds, as victims of the unlawful patterns of illegal activity, also suffered discrete losses as a result of these activities. The multifarious illegal activities through which Humana and Humana Insurance carried out their broad objectives consisted of a complex pattern of individual transactions and group transactions.

167. As part of the scheme to defraud and to obtain money by false pretenses, Humana Insurance sales personnel did not inform insureds that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those Plaintiffs at Humana-Sunrise.

168. As a part of the scheme to defraud and to obtain money by false pretenses, Humana and Humana Insurance prepared and disseminated, or caused to be prepared and disseminated, false, misleading, and fraudulent advertisements that stated Humana Insurance was passing along savings to its insureds, yet failed to disclose to those insureds that Humana-Sunrise had agreed to accept as payment

in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Those advertisements conferred a fraudulently unfair competitive advantage on Defendants.

B. Racketeering Activities

169. In carrying out the scheme to defraud and to obtain money by false pretenses, Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash engaged in, *inter alia*, conduct in violation of federal laws, viz., 18 U.S.C. § 1341, 18 U.S.C. § 1343, and 18 U.S.C. § 1503, as stated below:

1. 18 U.S.C. § 1341.

170. For the purpose of executing and/or attempting to execute the scheme to defraud and to obtain money by means of false or fraudulent pretenses, representations, or promises, Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash placed in post offices, and/or in authorized repositories for mail matter, matters and things to be sent or delivered by the Postal Service, and received matters and things therefrom, and knowingly caused to be delivered by mail those matters and things according to the directions thereon or at the place at which they were directed to be delivered by the persons to whom they were addressed, including without limitation as set forth in Appendix 1.

(1) In those matters and things Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash falsely and fraudulently represented to insureds as charges for medical treatment amounts that were far greater than the amounts that Humana-Sunrise had agreed with Humana Insurance to accept as payment in full for that medical treatment. Humana and/or Humana Insurance intentionally and knowingly made those material misrepresentations to insureds for the purpose of deceiving them and thereby obtaining financial gain. The insureds reasonably relied on those misrepresentations.

(2) In those matters and things Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash falsely and fraudulently failed to disclose to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Humana and/or Humana Insurance intentionally and knowingly failed to disclose that information to insureds for the purpose of deceiving them and thereby obtaining financial gain. The insureds reasonably relied on those nondisclosures.

Each such use of the mail during and in furtherance of the scheme to defraud and to obtain money by false pretenses violated 18 U.S.C. § 2 and 18 U.S.C. § 1341.

2. 18 U.S.C. § 1343.

171. For the purpose of executing and/or attempting to execute the scheme to defraud and to obtain money by means of false pretenses, representations, and promises, Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash transmitted or caused to be transmitted in interstate commerce wire, radio, and television transmissions, including without limitation as set forth in Appendix 2.

A. Defendants sent, or caused to be sent, interstate radio and television advertisements promoting the Humana Insurance group health insurance plan. Those radio and television advertisements were broadcast from locations in Nevada across state borders to persons located in Arizona and/or Utah. In those advertisements Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash never disclosed to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Those advertisements conferred a fraudulently unfair competitive advantage on Defendants. Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash intentionally and knowingly failed to disclose that information to insureds for the purpose of deceiving them and thereby obtaining financial gain in the form, inter alia, of a fraudulently unfair competitive advantage. The insureds reasonably relied on those nondisclosures.

B. Defendants used the interstate telephone lines to explain or discuss billings in order to collect co-payments from insureds for hospital charges incurred at Humana-Sunrise. Defendants maintained offices both in Las Vegas, Nevada and in Louisville, Kentucky. Defendants engaged in telephone conversations from their Nevada offices with Plaintiffs located in other states, including without limitation Arizona, California, and Utah, and from their Kentucky offices with Plaintiffs located in other states, including without limitation Arizona, California, Nevada, and Utah. In those telephone conversations Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash falsely and fraudulently represented to insureds as charges for medical treatment amounts that were far greater than the amounts that Humana-Sunrise had agreed with Humana Insurance to accept as payment in full for that medical treatment. Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash intentionally and knowingly made those material misrepresentations to insureds for the purpose of deceiving them and thereby obtaining financial gain. The insureds reasonably relied on those misrepresentations. Additionally, Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash failed to disclose to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing

along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash intentionally and knowingly failed to disclose that information to insureds for the purpose of deceiving them and thereby obtaining financial gain. The insureds reasonably relied on those nondisclosures.

C. On or about December 1, 1987, Defendants established a Louisville Claims Center in Louisville, Kentucky and a toll-free telephone line to that office for the specific purpose of handling claims from corporate Plaintiffs located in Nevada. Defendants engaged in telephone conversations from their Kentucky offices with corporate Plaintiffs located in Nevada. In those telephone conversations Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash falsely and fraudulently represented to insureds as charges for medical treatment amounts that were far greater than the amounts that Humana-Sunrise had agreed with Humana Insurance to accept as payment in full for that medical treatment. Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash intentionally and knowingly made those material misrepresentations to insureds for the purpose of deceiving them and thereby obtaining financial gain. The insureds reasonably relied on those misrepresentations. Additionally, Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash failed to disclose to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash intentionally and knowingly failed to disclose that information to insureds for the purpose of deceiving them and thereby obtaining financial gain. The insureds reasonably relied on those nondisclosures.

D. Defendants engaged in telephone conversations from their offices in Louisville, Kentucky with persons in Nevada in the offices of the government of the State of Nevada for the purpose of executing and/or attempting to execute Defendants' scheme to defraud and to obtain money by false pretenses.

E. Defendants have certified that during the period from 1984 through 1988, they engaged in an estimated 14,000,000 interstate telephone conversations. Those telephone conversations were in support of the scheme to defraud and to obtain money by false pretenses.

F. Humana, Inc. and/or Humana Insurance transferred millions of dollars by wire transfer from Nevada to other states and from other states to Nevada for the purpose of executing and/or attempting to execute Defendants' scheme to defraud and to obtain money by false pretenses, including without limitation as set forth in Appendix 2. Those interstate transfers of funds were in support of the scheme to defraud and to obtain money by false pretenses.

Each such use of interstate wire transmissions during and in furtherance of the scheme to defraud and to obtain money by means of false pretenses violated 18 U.S.C. § 2 and 18 U.S.C. § 1343.

3. 18 U.S.C. § 1503.

172. As part of the scheme to defraud and to obtain money by means of false pretenses, Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash corruptly influenced, obstructed, and impeded, or endeavored to influence, obstruct, and impede, the due administration of justice, including without limitation:

A. Humana and Humana Insurance (hereinafter referred to as "corporate Defendants") concealed from Plaintiffs 930 boxes or mroe of documents relevant to this litigation. Corporate Defendants' concealment of those 930 or more boxes of documents resulted in the improper suppression of evidence. Corporate Defendants concealed those 930 boxes or more of documents by multiple acts and omissions, including without limitation:

1. Corporate Defendants signed and served on Plaintiffs false responses to requests for production that Plaintiffs had issued to Defendants. In those responses Corporate Defendants failed to inform Plaintiffs of the aforementioned 930 boxes or more of documents that were responsive to Plaintiffs' requests, and Corporate Defendants failed to produce those 930 boxes or more of documents.

2. On or about August 30, 1991, Corporate Defendants falsely testified, in the sworn deposition of Corporate Defendants' counsel John Andris, that Corporate Defendants possessed none of the written documents contained in the aforementioned 930 boxes or more.

3. On or about September 4, 1991, Corporate Defendants falsely informed Plaintiffs that the only way to obtain the information that was in fact

contained in the aforementioned 930 boxes or more of documents was by retrieving it from computer records at a cost of $200,000 to Plaintiffs.

Corporate Defendants in fact knew they were in possession of those 930 boxes or more of documents and that those documents were responsive to Plaintiffs' requests for production. Corporate Defendants deliberately and willfully concealed that evidence from Plaintiffs, and consequently Corporate Defendants acted with the purpose of influencing, obstructing, and impeding the due administration of justice;

B. On or about January 18, 1990, Corporate Defendants signed, filed with this Court, and served on Plaintiffs a Second Motion to Dismiss, and on or about April 10, 1990, Corporate Defendants signed, filed with this Court, and served on Plaintiffs a Reply to Plaintiffs' Opposition thereto, wherein Corporate Defendants falsely indicated they had not engaged in interstate wire communications. Corporate Defendants in fact knew they had engaged in more than 14,000,000 interstate telephone communications and numerous interstate wire transfers of funds. Corporate Defendants deliberately and willfully concealed that evidence from Plaintiffs, and consequently Corporate Defendants acted with the purpose of influencing, obstructing, and impeding the due administration of justice.

C. On or about August 30, 1991, Corporate Defendants falsely testified, in the sworn deposition of Corporate Defendants' Director of Underwriting, James W. Keene, that Corporate Defendants had never maintained a "Jeopardy Committee." Keene in fact knew that Corporate Defendants had maintained a Jeopardy Committee over a period of several years, that he had

routinely communicated with members of that committee, and that the committee had generated numerous documents and records. The significance of Corporate Defendants' Jeopardy Committee is that it was authorized to reduce premiums for group health insurance below the levels dictated by normal actuarial principles, and in flagrant disregard of the rating methodology that Humana Insurance represented to the Insurance Division of Nevada as determining the premiums that Humana Insurance charged. The intervention of the Jeopardy Committee thereby allowed Humana Insurance to sell or renew policies of group health insurance that Humana Insurance was otherwise in jeopardy of not selling or renewing. In addition, the intervention allowed Humana Insurance to set premiums so low that Humana Insurance operated at a loss, in violation of Nevada insurance regulations.

Each such act or omission to corruptly influence, obstruct, and impede, or endeavor to influence, obstruct, and impede, the due administration of justice violated 18 U.S.C. § 2 and 18 U.S.C. § 1503.

173. At all times when Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash corruptly influenced, obstructed, and impeded, or endeavored to influence, obstruct, and impede, the due administration of justice, this litigation was a pending judicial proceeding, and consequently this Court was engaged in the due administration of justice.

C. The RICO "Enterprise"

174. Plaintiffs allege three alternative "enterprises" within the meaning of 18 U.S.C. § 1961(4), § 1962(a), and § 1962(c), and, with respect to each of those alternatives, an alternative "person" or "persons" within the meaning of

18 U.S.C. § 1961(3), § 1962(a), and § 1964(c), as set forth below.

175. Each enterprise was engaged in interstate commerce during the relevant times, and the activities of each enterprise affected interstate commerce during those times. Defendants provided medical services, and group health insurance for medical services, to persons who were residents of states other than Nevada. In furtherance of their business activities, Defendants contracted with and purchased from vendors located in states other than Nevada equipment and supplies that were delivered to Defendants' offices in Nevada from those other states by means of interstate transportation. In furtherance of their business activities, Defendants used the United States mails and interstate telephone and wire communications.

1. Humana as RICO "Enterprise" but not as RICO "Person"

176. Humana was an "enterprise" within the meaning of 18 U.S.C. § 1961(4), § 1962(a), and § 1962(c).

177. Each of Defendants Humana Insurance, Wendell Cherry, and William Larry Cash, when not acting as the enterprise, was a "person" within the meaning of 18 U.S.C. § 1961(3), § 1962(a), and § 1964(c).

2. Humana Insurance as RICO "Enterprise" but not as RICO "Person"

178. Humana Insurance was an "enterprise" within the meaning of 18 U.S.C. § 1961(4), § 1962(a), and § 1962(c).

179. Each of Defendants Humana, Wendell Cherry, and William Larry Cash Humana, when not acting as the enterprise, was a "person" within the meaning of 18 U.S.C. § 1961(3), § 1962(a), and § 1964(c).

3. The "Humana Group" as RICO "Enterprise"

180. Humana, Humana Insurance, Wendell Cherry, William Larry Cash, and the officers and directors of Humana and Humana Insurance were members of an association-in-fact, hereinafter referred to as the "Humana Group," that constituted an "enterprise" within the meaning of 19 U.S.C. § 1961(4), § 1962(a), and § 1962(c).

181. Each of Defendants Humana, Humana Insurance, Wendell Cherry, and William Larry Cash was a "person" within the meaning of 18 U.S.C. § 1961(3), § 1962(a), and § 1964(c).

182. The Humana Group shared common purposes, exhibited distinct divisions of responsibility, existed independently of the pattern of racketeering activity, and continued as an economic unit with the same members at its core during the period from 1984 through 1988.

a. Membership of the Humana Group

183. The Humana Group included, along with Defendants Humana, Humana Insurance, Wendell Cherry, and William Larry Cash, the officers and directors of Humana and Humana Insurance, all companies that prepared and/or disseminated advertising for Humana and/or Humana Insurance, and all sales brokers who sold policies of group health insurance issued by Humana Insurance.

b. Purposes and Responsibilities of the Humana Group.

184. The general purposes of the Humana Group were to provide medical services by Humana-Sunrise and insurance for medical services by Humana-Sunrise.

185. The specific purposes and responsibilities of Defendants Humana, Wendell Cherry, William Larry Cash, and of the officers and directors of Humana, included without limitation providing medical services by Humana-Sunrise.

186. The specific purposes and responsibilities of Defendants Humana Insurance, Wendell Cherry, William Larry Cash, and of the officers and directors of Humana Insurance, included without limitation providing insurance for medical services by Humana-Sunrise.

187. The specific purposes and responsibilities of companies that prepared and/or disseminated advertising for Defendant Humana included without limitation promoting the sale of medical services by Humana-Sunrise.

188. The specific purposes and responsibilities of companies that prepared and/or disseminated advertising for Defendant Humana Insurance and of sales brokers included without limitation promoting the sale of insurance for medical services by Humana-Sunrise.

c. Bases for the Humana Group

189. The bases for the association between and among Defendants Humana, Wendell Cherry, William Larry Cash, and the officers and directors of Humana included without limitation the articles of incorporation and bylaws of the firm.

190. The bases for the association between and among Defendants Humana Insurance, Wendell Cherry, William Larry Cash, and the officers and directors of Humana Insurance included without limitation the articles of incorporation and bylaws of the firm.

191. The bases for the association between Defendants Humana and Humana Insurance included without limitation the contractual preferred-provider agreements they entered into with each other.

192. The bases for the association between and among Defendant Humana and companies that prepared and/or disseminated advertising for Humana included without limi-

tation contractual agreements that Humana entered into with each of them.

193. The bases for the association between and among Defendant Humana Insurance and companies that prepared and/or disseminated advertising for Humana Insurance included without limitation contractual agreements that Humana Insurance entered into with each of them.

194. The bases for the association between and among Defendant Humana Insurance and sales brokers included without limitation contractual agreements that Humana Insurance entered into with each of them.

d. Time Period of the Humana Group

195. The Humana Group was intended to continue for an indefinite period of time. It has in fact continued from 1984 to the date of filing of this Third Amended Complaint.

e. Culpability of the Humana Group

196. The only members of the Humana Group that were aware of all or a portion of the scheme to defraud and to obtain money by means of false pretenses were Humana, Humana Insurance, Wendell Cherry, William Larry Cash, and the officers and directors of Humana and Humana Insurance.

D. Violations of 18 U.S.C.§ 1962(c)

197. Each Defendant, other than when it was the enterprise, was associated with one of the alternative enterprises and conducted or participated in, directly or indirectly, the conduct of the affairs of that enterprise through a pattern of racketeering activity within the meaning of 18 U.S.C. § 1961(1)(B), § 1961(5), and § 1962(c), viz.:

a. Multiple instances of violations of 18 U.S.C. § 1341;

b. Multiple instances of violations of 18 U.S.C. § 1343;

c. Multiple instances of violations of 18 U.S.C. § 1503.

198. Each Defendant, other than when it was the enterprise, aided and abetted each other Defendant, and persons not presently known to Plaintiffs, in committing the aforementioned violations of 18 U.S.C. 1962(c), all in violation of 18 U.S.C. § 2.

199. Plaintiffs were injured by Defendants' overt acts that violated 18 U.S.C. §2, § 1341, § 1343, and § 1503 during and in furtherance of Defendants' scheme to defraud, to obtain money by false pretenses, and/or to influence, obstruct, and impede the due administration of justice. Defendants' violations of 18 U.S.C. § 1341, § 1343, and § 1503 were additionally predicate acts for purposes of 18 U.S.C. § 1962(c).

E. Violations of 18 U.S.C. 1962(d) conspiracy to violate 18 U.S.C. § 1962(a)

200. Each Defendant, other than when it was the enterprise, conspired with each of the other Defendants, in violation of 18 U.S.C. § 1962(d), to violate 18 U.S.C. § 1962(a) by using or investing, directly or indirectly, in the acquisition of any interest, income, or the establishment or operation of one of the alternative enterprises, part of income derived, directly or indirectly, from a pattern of racketeering activity viz.:

a. Multiple instances of violations of 18 U.S.C. § 1341;

b. Multiple instances of violations of 18 U.S.C. § 1343;

c. Multiple instances of violations of 18 U.S.C. § 1503.

201. Plaintiffs were injured by Defendants' overt acts that violated 18 U.S.C. §2, § 1341, § 1343, and § 1503 during and in furtherance of Defendants' scheme to defraud, to

obtain money by false pretenses, and/or to influence, obstruct, and impede the due administration of justice. Defendants' violations of 18 U.S.C. § 1341, § 1343, and § 1503 were additionally predicate acts for purposes of 18 U.S.C. § 1962(a).

F. Violations of 18 U.S.C. § 1962(d) conspiracy to violate 18 U.S.C. § 1962(c)

1. Conduct or participation in the affairs of the enterprise

202. Each Defendant, other than when it was the enterprise, conspired with each of the other Defendants, in violation of 18 U.S.C. § 1962(d), to violate 18 U.S.C. § 1962(c) by conducting or participating, directly or indirectly, in the conduct of the affairs of one of the alternative enterprises through a pattern of racketeering activity within the meaning of 18 U.S.C. § 1961(1)(B), § 1961(5), and § 1962(c), viz.:

a. Multiple instances of violations of 18 U.S.C. § 1341;

b. Multiple instances of violations of 18 U.S.C. § 1343;

c. Multiple instances of violations of 18 U.S.C. § 1503.

203. Plaintiffs were injured by Defendants' overt acts that violated 18 U.S.C. §2, § 1341, § 1343, and § 1503 during and in furtherance of Defendants' scheme to defraud, to obtain money by false pretenses, and/or to influence, obstruct, and impede the due administration of justice. Defendants' violations of 18 U.S.C. § 1341, § 1343, and § 1503 were additionally predicate acts for purposes of 18 U.S.C. § 1962(c).

2. Conduct or participation in a pattern of racketeering activity.

204. Each Defendant, other than when it was the enterprise, conspired with each of the other Defendants, in violation of 18 U.S.C. § 1962(d), to violate 18 U.S.C. § 1962(c) by conducting or participating, directly or indirectly,

through the conduct of the affairs of one of the alternative enterprises, in a pattern of racketeering activity within the meaning of 18 U.S.C. § 1961(1)(B), § 1961(5), and § 1962(c), viz.:

a. Multiple instances of violations of 18 U.S.C. § 1341;

b. Multiple instances of violations of 18 U.S.C. § 1343;

c. Multiple instances of violations of 18 U.S.C. § 1503.

205. Plaintiffs were injured by Defendants' overt acts that violated 18 U.S.C. §2, § 1341, § 1343, and § 1503 during and in furtherance of Defendants' scheme to defraud, to obtain money by false pretenses, and/or to influence, obstruct, and impede the due administration of justice. Defendants' violations of 18 U.S.C. § 1341, § 1343, and § 1503 were additionally predicate acts for purposes of 18 U.S.C. § 1962(c).

G. Requested Relief

206. By reason of the violations of 18 U.S.C. § 2 and § 1962(c) and (d) committed by Defendants, it is estimated that the actual damages of the RICO class are in excess of $181,034,570.00, the principal of which is subject to trebling.

207. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered; Waite, Schneider, Bayless & Chesley Co., L.P.A.; Cummings, Cummings & Dudenhefer; and Gauthier & Murphy to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor.

VII

FOURTH CLAIM FOR RELIEF

(Violations of Nevada Racketeering Laws)

A. General Allegations

208. Plaintiffs reassert and reallege each and every allegation contained in paragraphs 1 through 207 of this Third Amended Complaint as though fully set forth at this point.

209. Each Plaintiff and each member of the designated class that Plaintiffs represent is a "person who is injured in his business or property by reason of any violation of NRS 207.400" within the meaning of Nev. Rev. Stat. § 207. 470(1).

210. With respect to their activities alleged herein, Defendants acted at all times with malice, intent, and knowledge, and with a wanton and reckless disregard for the rights of Plaintiffs.

211. With respect to the activities alleged herein, each Defendant aided and abetted each other Defendant, and others not presently known to Plaintiffs, in committing those activities, all in violation of the statutes set forth herein, and specifically in violation of Nev. Rev. Stat. § 195.020. Each Defendant agreed to the operation of the scheme to defraud and to obtain money by false pretenses.

212. With respect to the activities alleged herein, other than those involving violations of Nev. Rev. Stat. § 207. 400(h), each Defendant conspired with each other Defendant, and with others not presently known to Plaintiffs, in committing those activities, all in violation of the statutes set forth herein, and specifically in violation of Nev. Rev. Stat. § 207.400(1)(h). Each Defendant agreed to the conspiracy to defraud and to obtain money by false pretenses.

213. As part of a scheme to defraud Plaintiffs and to obtain money from Plaintiffs by false pretenses, by charging Plaintiffs a different per diem per patient day on their co-payments, Humana and Humana Insurance entered into a secret agreement (the "Agreement"). Pursuant to the Agreement, Humana Insurance agreed to pay Humana-Sunrise a discounted amount for that portion of the hospital charges for which it was responsible. The portion of the charges paid by others, however, was not discounted but was still based on the usual and customary rate.

214. Humana Insurance did not reduce premiums in the amount discounted. It was part of the scheme to defraud and to obtain money by false pretenses that Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash used false and fraudulent pretenses, representations and promises calculated to deceive persons of ordinary prudence and due care and made material nondisclosures and concealment of fact and information important to the insureds, including without limitation the existence of the secret agreement and that Humana was billing Humana Insurance at a different per diem, all so as to unlawfully, intentionally, and willfully, and with the intent to defraud, that is, knowingly and with specific intent to deceive in order to cause financial gain to themselves, procure secret profits to the use and benefit of themselves and others and to the detriment of the insureds consisting of the named Plaintiffs, as representatives of a class pursuant to Fed. R. Civ. P. 23.

215. The scheme to defraud and to obtain money by false pretenses evolved over time a pattern of illegal activity that inflicted discrete harms on the insureds and others. The insureds, as victims of the unlawful patterns of illegal activity, also suffered discrete losses as a result of these activities. The multifarious illegal activities through which the broad objectives of Humana and Humana Insurance were

carried out consisted of a complex pattern of individual transactions and group transactions.

216. As part of the scheme to defraud and to obtain money by false pretenses, Humana Insurance sales personnel did not inform insureds that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those Plaintiffs at Humana-Sunrise.

217. As a part of the scheme to defraud and to obtain money by false pretenses, Humana and Humana Insurance prepared and disseminated, or caused to be prepared and disseminated, false, misleading, and fraudulent advertisements that stated Humana Insurance was passing along savings to its insureds, yet failed to disclose to those insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Those advertisements conferred a fraudulently unfair competitive advantage on Defendants.

B. Racketeering Activities

218. In carrying out the scheme to defraud and to obtain money by false pretenses, Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash engaged in, *inter alia*, conduct in violation of Nevada law, viz., Nev. Rev. Stat. § 205.380, § 686a.291(1), § 686A.291(2), and § 686A.291(3), as stated below:

1. Nev. Rev. Stat. § 205.380.

219. As part of the scheme to defraud and to obtain money by means of false pretenses, Defendants Humana, Wendell Cherry, and/or William Larry Cash Humana obtained money in an amount in excess of $100, in the form of premiums and co-payments from Plaintiffs, by knowingly and designedly, and with intent to cheat and defraud Plaintiffs, making false and fraudulent representations thereto and by falsely and fraudulently failing to disclose information material to transactions therewith.

220. The false and fraudulent representations were that Humana Insurance would pay 80% of the charges, beyond the deductible, incurred by insured employees for medical treatment at Humana-Sunrise. The information material to transactions with Plaintiffs that Defendants falsely and fraudulently failed to disclose to insureds was that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

A. Defendants made those misrepresentations, and failed to disclose that information, orally and in written form to employers who were to pay all of a portion of the premiums for group health insurance issued by Humana Insurance. Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash intentionally and knowingly failed to disclose that information to employers for the purpose of deceiving

them and thereby obtaining financial gain. Those employers reasonably relied on the misrepresentations and failures to disclose in deciding to purchase group health insurance issued by Humana Insurance. Consequently those employers grossly overpaid for group health insurance issued by Humana Insurance.

B. Defendants made those misrepresentations, and failed to disclose that information, orally and in written form to employees who were to pay all or a portion of premiums for group health insurance issued by Humana Insurance. Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash intentionally and knowingly failed to disclose that information to employers for the purpose of deceiving them and thereby obtaining financial gain. Those employees reasonably relied on the misrepresentations and failures to disclose in deciding to participate in and pay all or a portion of the premiums for group health insurance issued by Humana Insurance. Consequently those employees grossly overpaid for group health insurance issued by Humana Insurance.

C. Defendants made those misrepresentations, and failed to disclose that information, orally and in written form to employees who were thereafter insured by group health insurance issued by Humana Insurance and who obtained medical treatment at Humana-Sunrise. Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash intentionally and knowingly failed to disclose that information to employees for the purpose of deceiving them and thereby obtaining financial gain. Those employees reasonably relied on the misrepresentations and failures to disclose in deciding to obtain medical treatment at Humana-Sunrise. Consequently those employees grossly overpaid for medical treatment they received at Humana-Sunrise.

D. Defendants made those misrepresentations, and failed to disclose that information, in bills and statements of charges that Humana-Sunrise sent to insureds that falsely and fraudulently represented as charges for medical treatment amounts that were far greater than the amounts that Humana-Sunrise had agreed with Humana Insurance to accept as payment in full for that medical treatment, and that falsely and fraudulently failed to disclose to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash intentionally and knowingly failed to disclose that information to insureds for the purpose of deceiving them and thereby obtaining financial gain. Those insureds reasonably relied on those misinterpretations and failures to disclose. Consequently those insureds grossly overpaid for medical treatment they received at Humana-Sunrise.

E. Defendants made those representations, and failed to disclose that information, in explanations of benefits that Humana Insurance sent to insureds that falsely and fraudulently represented as charges for medical treatment amounts that were far greater than the amounts that Humana-Sunrise had agreed with Humana Insurance to accept as payment in full for that medical treatment, and that falsely and fraudulently failed to

disclose to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash intentionally and knowingly failed to disclose that information to insureds for the purpose of deceiving them and thereby obtaining financial gain. The insureds reasonably relied on those failures to disclose. Additionally, those explanations of benefits falsely and fraudulently represented that Humana Insurance had paid or would pay percentages and/or dollar portions of those charges that Humana Insurance in fact had not paid and would not pay. The insureds reasonably relied on those misrepresentations. Consequently those insureds grossly overpaid for medical treatment they received at Humana-Sunrise.

2. Nev. Rev. Stat. § 686A.291(1).

221. As part of the scheme to defraud and to obtain money by means of false pretenses, Defendants Humana, Wendell Cherry, and/or William Larry Cash knowingly and willfully presented or caused to be presented to Humana Insurance false, incomplete, and misleading information concerning a material fact, as a part of and in support of claims for payment or reimbursement.

222. The false, incomplete, and misleading information was the amounts that Humana charged for medical treatment, at Humana-Sunrise, of persons insured by Humana Insurance. That information was false, incomplete, and misleading in that it failed to disclose that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash intentionally and knowingly failed to disclose that information.

223. Humana presented or caused to be presented to Humana Insurance that information both in written form and by electronic data transmission as claims for payment or reimbursement of Humana by Humana Insurance for medical treatment at Humana-Sunrise of persons insured by Humana Insurance, as operations statistics reports, and as month-end reports.

3. Nev. Rev. Stat. § 686A.291(2).

224. As part of the scheme to defraud and to obtain money by means of false pretenses, Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash assisted, abetted, and conspired with each other to prepare and present, or cause to be prepared and presented, false, incomplete, and misleading information, both written and oral, concerning material facts as part of and in support of claims for payments, reimbursements and other benefits.

225. The false information was that Humana Insurance would pay 80% of the charges, beyond the deductible, incurred by insured employees for medical treatment at

Humana-Sunrise. Additionally, that information was incomplete and misleading in that it failed to disclose to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash intentionally and knowingly failed to disclose that information to insureds for the purpose of deceiving them and thereby obtaining financial gain. The insureds reasonably relied on those failures to disclose.

A. Defendants assisted, abetted, and conspired with each other to prepare and present, or cause to be prepared and presented, that information orally and in written form to employers who were to pay all of a portion of the premiums for group health insurance issued by Humana Insurance. Those employers reasonably relied on the information in deciding to purchase group health insurance issued by Humana Insurance. Consequently those employers grossly overpaid for group health insurance issued by Humana Insurance.

B. Defendants assisted, abetted, and conspired with each other to prepare and present, or cause to be prepared and presented, that information orally and in written form to employees who were to pay all or a portion of premiums for group health insurance issued by Humana Insurance. Those employees reasonably relied on the information in deciding to participate in and pay all or a portion of the premiums for group

health insurance issued by Humana Insurance. Consequently those employees grossly overpaid for group health insurance issued by Humana Insurance.

C. Defendants assisted, abetted, and conspired with each other to prepare and present, or cause to be prepared and presented, that information orally and in written form to employees who were thereafter insured by group health insurance issued by Humana Insurance and who obtained medical treatment at Humana-Sunrise. Those employees reasonably relied on the information in deciding to obtain medical treatment at Humana-Sunrise. Consequently those employees grossly overpaid for medical treatment they received at Humana-Sunrise.

D. Defendants assisted, abetted, and conspired with each other to prepare and present, or cause to be prepared and presented, that information in bills and statements of charges that Humana-Sunrise sent to insureds that falsely, incompletely, and misleadingly represented as charges for medical treatment amounts that were far greater than the amounts that Humana-Sunrise had agreed with Humana Insurance to accept as payment in full for that medical treatment, that falsely, incompletely, and misleadingly failed to disclose to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Those insureds reasonably

relied on that information and those failures to disclose. Consequently those insureds grossly overpaid for medical treatment they received at Humana-Sunrise.

E. Defendants assisted, abetted, and conspired with each other to prepare and present, or cause to be prepared and presented, that information in explanations of benefits that Humana Insurance sent to insureds that falsely, incompletely, and misleadingly represented as charges for medical treatment amounts that were far greater than the amounts that Humana-Sunrise had agreed with Humana Insurance to accept as payment in full for that medical treatment, and that falsely, incompletely, and misleadingly failed to disclose to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Those insureds reasonably relied on the information and failures to disclose. Consequently those insureds grossly overpaid for medical treatment they received at Humana-Sunrise.

4. Nev. Rev. Stat.§ 686A.291(3).

226. As part of the scheme to defraud and to obtain money by means of false pretenses, Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash concealed from and failed to disclose to Plaintiffs events affecting the initial and continued right of Plaintiffs to benefits and payments to which Plaintiffs were entitled.

227. Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash concealed from and failed to disclose to Plaintiffs that Defendants Humana and Humana Insurance had entered, at varying times, into an agreement and amendments thereto whereby Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and whereby Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services. Humana Insurance did not pass along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Defendants Humana, Humana Insurance, Wendell Cherry, and/or William Larry Cash intentionally and knowingly failed to disclose that information to Plaintiffs for the purpose of deceiving them and thereby obtaining financial gain. Plaintiffs reasonably relied on those failures to disclose.

228. The agreement and amendments thereto affected the initial and continued right of Plaintiffs to benefits, in that the agreement and amendments thereto should have reduced or discounted, but did not, the amount of charges, beyond the deductible, for medical treatment incurred at Humana-Sunrise with respect to which Plaintiffs were obligated to pay 20%.

229. The agreement and amendments thereto affected the initial and continued right of Plaintiffs to payments by Humana Insurance, in that the agreement and amendments thereto should have provided, but did not, that Humana Insurance would pay 80% of the charges that Humana-Sunrise agreed to accept as payment in full for medical treatment incurred by Plaintiffs. Plaintiffs were entitled to those 80% payments, in that Plaintiffs were the beneficiaries

of contracts entered into by Humana Insurance whereby Humana Insurance was obligated to pay that 80%.

230. The agreement and amendments thereto affected the initial and continued right of Plaintiffs to benefits, in that the agreement and amendments thereto should have provided, but did not, for Humana Insurance to pass along to its insureds the savings that Humana Insurance obtained by negotiating a discount on those charges.

C. The RICO "Enterprise"

231. Plaintiffs allege three alternative "enterprises" within the meaning of Nev. Rev. Stat. § 207.380, § 207.400(1)(a)(2), and § 207.400(1)(c), and, with respect to each of those alternatives, an alternative "person" or "persons" within the meaning of Nev. Rev. Stat. § 207.400(1), § 205.380, and § 686A.291, as set forth below.

232. Each enterprise was engaged in interstate commerce during the relevant times, and the activities of each enterprise affected interstate commerce during those times. Defendants provided medical services, and group health insurance for medical services, to persons who were residents of states other than Nevada. In furtherance of their business activities, Defendants contracted with and purchased from vendors located in states other than Nevada equipment and supplies that were delivered to Defendants' offices in Nevada from those other states by means of interstate transportation. In furtherance of their business activities, Defendants used the United States mails and interstate telephone and wire communications.

1. Humana as RICO "Enterprise" but not as RICO "Person"

233. Humana was an "enterprise" within the meaning of Nev. Rev. Stat. § 207.380, § 207.400(1)(a)(2), and § 207.400(1)(c).

234. Each of Defendants Humana Insurance, Wendell Cherry, and/or William Larry Cash was a "person" within the meaning of Nev. Rev. Stat. 207.400(1), § 205.380, and § 686A.291.

2. Humana Insurance as Rico "Enterprise" but not as RICO "Person"

235. Humana Insurance was an "enterprise" within the meaning of Nev. Rev. Stat. § 207.380, § 207.400(1)(a)(2), and § 207.400(1)(c).

236. Each of Defendants Humana, Wendell Cherry, and/or William Larry Cash was a "person" within the meaning of Nev. Rev. Stat. § 207.400(1), § 205.380, and § 686A.291.

3. The "Humana Group" as RICO "Enterprise"

237. Humana, Humana Insurance, Wendell Cherry, William Larry Cash, and the officers and directors of Humana and Humana Insurance were members of an association-in-fact, hereinafter referred to as the "Humana Group," that constituted an "enterprise" within the meaning of Nev. Rev. Stat. § 207.380, § 207.400(1)(a)(2), and § 207.400(1)(c).

238. Each of Defendants Humana, Humana Insurance, Wendell Cherry, and William Larry Cash, when not acting as a member of the enterprise, was a "person" within the meaning of Nev. Rev. Stat. § 207.400(1), § 205.380, and § 686A.291.

239. The Humana Group shared common purposes, exhibited distinct divisions of responsibility, existed independently of the pattern of racketeering activity, and continued as an economic unit with the same members at its core during the period from 1984 through 1988.

a. Membership of the Humana Group

240. The Humana Group included, along with Defendants Humana, Humana Insurance, Wendell Cherry, and William Larry Cash, the officers and directors of Humana and Humana Insurance, all companies that prepared and/or disseminated advertising for Humana and/or Humana Insurance, and all sales brokers who sold policies of group health insurance issued by Humana Insurance.

b. Purposes and Responsibilities of the Humana Group

241. The general purposes and responsibilities of the Humana Group were to provide medical services by Humana-Sunrise and insurance for medical services by Humana-Sunrise.

242. The specific purposes and responsibilities of Defendants Humana, Wendell Cherry, William Larry Cash, and of the officers and directors of Humana, included without limitation providing medical services by Humana-Sunrise.

243. The specific purposes and responsibilities of Defendants Humana Insurance, Wendell Cherry, William Larry Cash, and of the officers and directors of Humana Insurance, included without limitation providing insurance for medical services by Humana-Sunrise.

244. The specific purposes and responsibilities of companies that prepared and/or disseminated advertising for Defendant Humana included without limitation promoting the sale of medical services by Humana-Sunrise.

245. The specific purposes and responsibilities of companies that prepared and/or disseminated advertising for Defendant Humana Insurance and of sales brokers included without limitation promoting the sale of insurance for medical services by Humana-Sunrise.

c. Bases for the Humana Group

246. The bases for the association between and among Defendants Humana, Wendell Cherry, and William Larry Cash, and the officers and directors of Humana included without limitation the articles of incorporation and bylaws of the firm.

247. The bases for the association between and among Defendants Humana Insurance, Wendell Cherry, and William Larry Cash, and the officers and directors of Humana Insurance included without limitation the articles of incorporation and bylaws of the firm.

248. The bases for the association between Defendants Humana and Humana Insurance included without limitation the contractual preferred-provider agreements they entered into with each other.

249. The bases for the association between and among Defendant Humana and companies that prepared and/or disseminated advertising for Humana included without limitation contractual agreements that Humana entered into with each of them.

250. The bases for the association between and among Defendant Humana Insurance and companies that prepared and/or disseminated advertising for Humana Insurance included without limitation contractual agreements that Humana Insurance entered into with each of them.

251. The bases for the association between and among Defendant Humana Insurance and sales brokers included without limitation contractual agreements that Humana Insurance entered into with each of them.

d. Time Period of the Humana Group

252. The Humana Group was intended to continue for an indefinite period of time. It has in fact continued from 1984 to the date of filing of this Third Amended Complaint.

e. Culpability of the Humana Group

253. The only members of the Humana Group that were aware of all or a portion of the scheme to defraud and to obtain money by means of false pretenses were Humana, Humana Insurance, Wendell Cherry, William Larry Cash, and the officers and directors of Humana and Humana Insurance.

D. Violations of Nev. Rev. Stat. § 207.400(1)(a)(2)

254. Each Defendant, other than when it was the enterprise, with criminal intent used or invested, directly or indirectly, to acquire an interest in or to establish or operate one of the alternative enterprises, proceeds the Defendant received that were derived, directly or indirectly, from racketeering activity, within the meaning of Nev. Rev. Stat. § 207.360(26), § 207.360(30), and § 207.400(1)(a)(2), viz.:

a. Multiple instances of violations of Nev. Rev. Stat. § 205.380;

b. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(1);

c. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(2);

d. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(3).

255. Plaintiffs were injured by Defendants' overt acts that violated Nev. Rev. Stat. § 195.020, § 205.380, § 686A. 291(1), § 686A.291(2), and § 686A.291(3) during and in furtherance of Defendants' scheme to defraud and to obtain money by false pretenses. Defendants' violations of Nev. Rev. Stat. § 205.380, § 686A.291(1), § 686A.291(2), and § 686A.291(3) were additionally predicate acts for purposes of Nev. Rev. Stat. § 270.400(1)(a)(2).

E. Violations of Nev. Rev. Stat. § 207.400(1)(c)(1)

256. Each Defendant, other than when it was the enterprise, was associated with one of the alternative enterprises and conducted or participated in, directly or indirectly, the affairs of one of the alternative enterprises through racketeering activity within the meaning of Nev. Rev. Stat. § 207.360(26). § 207.360(30), and § 207.400(1)(c)(1), viz.:

a. Multiple instances of violations of Nev. Rev. Stat. § 205.380;

b. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(1);

c. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(2);

d. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(3).

257. Plaintiffs were injured by Defendants' overt acts that violated Nev. Rev. Stat. § 195.020, § 205.380, § 686A.291(1), § 686A.291(2), and § 686A.291(3) during and in furtherance of Defendants' scheme to defraud and to obtain money by false pretenses. Defendants' violations of Nev. Rev. Stat. § 205.380, § 686A.291(1), § 686A.291(2), and § 686A.291(3) were additionally predicate acts for purposes of Nev. Rev. Stat. § 207.400(1)(c)(1).

F. Violations of Nev. Rev. Stat. § 207.400(1)(c)(2)

258. Each Defendant, other than when it was the enterprise, was associated with one of the alternative enterprises and conducted or participated in, directly or indirectly, through the affairs of that enterprise, racketeering activity within the meaning of Nev. Rev. Stat. § 207.360(26), § 207.360(30), and § 207.400(1)(c)(2), viz.:

a. Multiple instances of violations of Nev. Rev. Stat. § 205.380;

b. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(1);

c. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(2);

d. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(3).

259. Plaintiffs were injured by Defendants' overt acts that violated Nev. Rev. Stat. § 195.020, § 205.380, § 686A.291(1), § 686A.291(2), and § 686A.291(3) during and in furtherance of Defendants' scheme to defraud and to obtain money by false pretenses. Defendants' violations of Nev. Rev. Stat. § 205.380, § 686A.291(1), § 686A.291(2), and § 686A.291(3) were additionally predicate acts for purposes of Nev. Rev. Stat. § 207.400(1)(c)(2).

G. Violations of Nev. Rev. Stat. § 207.400(1)(h) to violate Nev. Rev. Stat. § 207.400(1)(a)(2)

260. Each Defendant, other than when it was the enterprise, conspired with each of the other Defendants to use or invest, directly or indirectly, for the purpose of acquiring an interest in or to establish or operate one of the alternative enterprises, proceeds derived, directly or indirectly, from racketeering activity within the meaning of Nev. Rev. Stat. § 207.360(26), § 207.360(30), and § 207.400(1)(a)(2), viz.:

a. Multiple instances of violations of Nev. Rev. Stat. § 205.380;

b. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(1);

c. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(2);

d. Multiple instances of violations of Rev. Rev. Stat. § 686A.291(3).

261. Plaintiffs were injured by Defendants' overt acts that violated Nev. Rev. Stat. § 195.020, § 205.380, § 686A.291(1), § 686A.291(2), and § 686A.291(3) during and in furtherance of Defendants' scheme to defraud and to obtain money by false pretenses. Defendants' violations of Nev. Rev. Stat. § 205.380, § 686A.291(1), § 686A.291(2), and § 686A.291(3) were additionally predicate acts for purposes of Nev. Rev. Stat. § 207.400(1)(a)(2).

H. Violations of Nev. Rev. Stat. § 207.400(1)(h) to violate Nev. Rev. Stat. § 207.400(1)(c)(1)

262. Each Defendant, other than when it was the enterprise, associated with one of the alternative enterprises and conspired, in violation of Nev. Rev. Stat. § 207.400(1)(h), with each of the other Defendants to conduct or participate in, directly or indirectly, the affairs of that enterprise through racketeering activity within the meaning of Nev. Rev. Stat. § 207.360(26). § 207.360(30), and § 207.400(1)(c)(1), viz.:

a. Multiple instances of violations of Nev. Rev. Stat. § 205.380;

b. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(1);

c. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(2);

d. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(3).

263. Plaintiffs were injured by Defendants' overt acts that violated Nev. Rev. Stat. § 195.020, § 205.380, § 686A.291(1), § 686A.291(2), and § 686A.291(3) during and in

furtherance of Defendants' scheme to defraud and to obtain money by false pretenses. Defendants' violations of Nev. Rev. Stat. § 205.380, § 686A.291(1), § 686A.291(2), and § 686A.291(3) were additionally predicate acts for purposes of Nev. Rev. Stat. § 207.400(1)(c)(1).

I. Violations of Nev. Rev. Stat. § 207.400(1)(h) to violate Nev. Rev. Stat. § 207.400(1)(c)(2)

264. Each Defendant, other than when it was the enterprise, was associated with one of the alternative enterprises and conspired, in violation of Nev. Rev. Stat. § 207.400 (1)(h), with each other Defendant to conduct or participate in, directly or indirectly, through the affairs of that enterprise, racketeering activity within the meaning of Nev. Rev. Stat. § 207,360(26), § 207.360(30), and § 207.400(1)(c)(2), viz.:

a. Multiple instances of violations of Nev. Rev. Stat. § 205.380;

b. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(1);

c. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(2);

d. Multiple instances of violations of Nev. Rev. Stat. § 686A.291(3).

265. Plaintiffs were injured by Defendants' overt acts that violated Nev. Rev. Stat. § 195.020, § 205.380, § 686A. 291(1), § 686A.291(2), and § 686A.291(3) were additionally predicate acts for purposes of Nev. Rev. Stat. § 207. 400(1)(c)(2).

J. Requested Relief

266. By reason of the violations of Nev. Rev. Stat. § 195.020, and § 207.400 (1)(a)(2), (1)(c)(1), (1)(c)(2), and

(1)(h) committed by Defendants, it is estimated that the approximate actual damages of the RICO classes are in excess of $181,034,570.00, the principal of which is subject to trebling.

267. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered; Waite, Schneider, Bayless & Chesley Co., L.P.A.; Cummings, Cummings & Dudenhefer; and Gauthier & Murphy to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor.

VIII

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray for judgment against Defendants, jointly and/or severally, where applicable in each claim for relief as follows:

1. An amount in excess of $84,520,143.00 based on the ERISA violations by Humana Insurance, Wendell Cherry, and William Larry Cash on the First Claim for Relief.

2. Imposition of a constructive trust in the amount of all monies received as a result of the scheme, with Plaintiffs to be named as the beneficiaries of the trust on the First Claim for Relief.

3. Declaratory judgment and permanent injunction establishing the rights and duties between the parties and for judgment requiring Humana Insurance and William Larry Cash to cease and desist from the wrongful conduct described in the First Claim for Relief.

4. General, special, and compensatory damages in an amount in excess of $181,034,570.00 on the Second Claim for Relief, which damages are subject to trebling (excluding interest) for a total amount in excess of $421,426,569.00.

5. For declaratory judgment and permanent injunction requiring Defendant to cease and desist the wrongful conduct described in the Second Claim for Relief.

6. General, special, and compensating damages in an amount in excess of $181,034,570.00 on the Third Claim for Relief, which damages are subject to trebling (excluding interest) for a total amount in excess of $421,426,569.00.

7. General, special, and compensating damages in an amount in excess of $181,034,570.00 on the Fourth Claim for Relief, which damages are subject to trebling (excluding interest) for a total amount in excess of $421,426,569.00.

8. Costs of suit and fees incurred herein.

9. Any further and additional relief that this Court may deem just and equitable.

DATED this 31st day of October, 1991.

JONES, JONES, CLOSE
& BROWN, CHARTERED

By_____
J. RANDALL JONES, ESQ.
WILL KEMP, ESQ.
300 South Fourth Street
Las Vegas, Nevada 89101

WAITE, SCHNEIDER, BAYLESS
& CHESLEY CO., L.P.A.

By_____
STANLEY M. CHESLEY, ESQ.
1515 Central Trust Tower
Fourth and Vine Streets
Cincinnati, Ohio 45202

CUMMINGS, CUMMINGS & DUDENHEFER

By_____
JOHN L. CUMMINGS III, ESQ.
416 Gravier Street
New Orleans, LA 70130

GAUTHIER & MURPHY

By_____
WENDELL GAUTHIER, ESQ.
3500 North Hullen Street
Metairie, LA 70002

ATTORNEY FOR PLAINTIFFS

Plaintiffs demand a trial by jury on all issues so triable.

JONES, JONES, CLOSE
& BROWN, CHARTERED

By_____
J. RANDALL JONES, ESQ.
WILL KEMP, ESQ.
300 South Fourth Street
Suite 700
Las Vegas, Nevada 89101

Appendix A

Use of the United States Mails During and in Furtherance of the Scheme to Defraud

	Description	Date	From	To
1.	Statement of charges by Humana-Sunrise and amounts paid by Humana Insurance [EOB]	2/7/89	H-Insurance	Andrews
2.	Premium invoice for 8/1/85 - 8/31/85	not shown	Humana, Inc.	Best Glass
3.	Premium invoice for 7/1/86 - 7/31/86	not shown	Humana, Inc.	Best Glass
4.	Premium invoice for 7/1/87 - 7/31/87	not shown	Humana, Inc.	Best Glass
5.	Premium invoice for 7/1/88 - 7/31/88	not shown	Humana, Inc.	Best Glass
6.	Letter soliciting policy renewal and quoting premiums	4/29/88	H-Insurance	Best Glass
7.	Cover letter for Humana Insurance brochure setting forth benefits of policy	not shown	H-Insurance	Bratton
8.	Humana Insurance enrollment form	9/10/87	Bratton	H-Insurance
9.	Statement of charges by Humana-Sunrise and amounts paid by insured	1/22/88	H-Sunrise	Staves
10.	Patient account statement	3/21/88	H-Sunrise	Bratton
11.	Patient account statement	4/17/88	H-Sunrise	Bratton
12.	Patient account statement	5/20/88	H-Sunrise	Bratton
13.	Request for payment of charges by Humana-Sunrise	5/28/88	H-Sunrise	Bratton
14.	Patient account statement	6/11/88	H-Sunrise	Bratton

15.	Request for payment of charges by Humana-Sunrise	7/2/88	H-Sunrise	Bratton
16.	Patient account statement	11/12/88	H-Sunrise	Bratton
17.	Request for payment of charges by Humana-Sunrise	12/3/88	H-Sunrise	Bratton
18.	Statement of charges by Humana-Sunrise and amounts paid by Humana Insurance [EOB]	1/31/89	H-Insurance	Bratton
19.	Statement of charges by Humana-Sunrise and amounts paid by Humana Insurance [EOB]	6/8/89	H-Insurance	Bratton
20.	Statement of charges by Humana-Sunrise and amounts paid by Humana Insurance [EOB]	6/23/89	H-Insurance	Bratton
21.	Patient account statement	6/26/89	H-Sunrise	Bratton
22.	Detailed statement of charges by Humana-Sunrise	9/22/86	H-Sunrise	Buehler
23.	Detailed statement of charges by Humana-Sunrise	10/20/88	H-Sunrise	Buehler
24.	Patient account statement	10/3/89	H-Sunrise	Buehler
25.	Detailed statement of charges by Humana-Sunrise	10/21/87	H-Sunrise	Cade
26.	Detailed statement of charges by Humana-Sunrise	9/18/86	H-Sunrise	Forsyth
27.	Patient account statement	10/25/86	H-Sunrise	Forsyth
28.	Statement of charges by Humana-Sunrise and amounts paid by insured	10/27/86	H-Sunrise	Forsyth
29.	Patient account statement	11/9/86	H-Sunrise	Forsyth

30.	Statement of charges by Humana-Sunrise and amounts paid by insured	12/24/86	H-Sunrise	Forsyth
31.	Detailed statement of charges by Humana-Sunrise	10/20/88	H-Sunrise	Staves
32.	Patient account statement	11/16/88	H-Sunrise	Staves
33.	Patient account statement	12/30/88	H-Sunrise	Staves
34.	Detailed statement of charges by Humana-Sunrise	1/9/89	H-Sunrise	Staves
35.	Statement of charges by Humana-Sunrise and amounts paid by insured	1/9/89	H-Sunrise	Staves
36.	Patient account statement	1/9/89	H-Sunrise	Staves
37.	Patient account statement	1/10/89	H-Sunrise	Staves
38.	Statement of charges by Humana-Sunrise and amounts paid by Humana Insurance [EOB]	1/11/89	H-Insurance	Staves
39.	Patient account statement	1/12/89	H-Sunrise	Staves
40.	Statement of charges by Humana-Sunrise and amounts paid by Humana Insurance [EOB]	1/19/89	H-Insurance	Staves
41.	Patient account statement	1/20/89	H-Sunrise	Staves
42.	Request for payment of charges by Humana-Sunrise	1/29/89	H-Sunrise	Staves
43.	Statement of charges by Humana-Sunrise and amounts paid by Humana Insurance [EOB]	10/8/89	H-Insurance	Staves
44.	Patient account statement	10/10/89	H-Sunrise	Staves

Appendix B

Interstate Telephone and Wire Communications During and in Furtherance of the Scheme to Defraud

	Description	Date	From	To
1.	Approximately 14,000,000 interstate telephone communications involving business activities of Defendants [*see* Exhibit 1]	1984-1988	Defendants, Plaintiffs, and others	Defendants, Plaintiffs, and others
2.	Indeterminate number of interstate telephone Communications involving claims payments by Defendants [*see* Exhibit 2]	1987-1988	Defendants, Plaintiffs, and others	Defendants, Plaintiffs, and others
3.	Interstate telephone communications involving charges by Humana-Sunrise and co-payments by Humana Insurance [*see* Exhibit 3]	1986-1987	Rudolph K. Whalen [Arizona]	H-Sunrise [Nevada], H-Insurance [Nevada], Mutual Administrators [Nevada]
4.	Interstate telephone communication involving business activities of Defendants [*see* Exhibit 4]	5/2/89	John Andris of Humana, Inc. [Kentucky]	Herschell Dunham of Nevada Division of Insurance [Nevada]
5.	Interstate wire transfer of $1,501,335.63 [*see* Exhibit 5]	3/2/84	Humana, Inc. [Kentucky]	H-Insurance [Nevada]
6.	Interstate wire transfer of $ [illegible] [*see* Exhibit 6]	6/17/87	H-Insurance [Nevada]	First National Bank [Boston]

CERTIFICATION

I, William E. Lawrence, certify the following:

1. I am Vice President - Telecommunications for Humana Inc. and have been responsible for arranging local and long distance telephone services for Humana Inc. and its subsidiaries for eleven (11) years.

2. I have reviewed the Plaintiff's Fifth Request for Production of Documents in the case styled *Mary Forsyth, et al. vs. Humana Inc., et al.*, Case No. CV-S-89-249-PMP (LRL).

3. Long distance telephone records of Humana Inc. for the period 1984 through 1988, including those records of long distance calls made between the corporate office of Humana Inc. in Louisville, Kentucky and Humana Hospital-Sunrise and Humana Health Insurance of Nevada's market office, both located in Las Vegas, Nevada, are maintained in the form of copies of bills or invoices from various long distance carriers, and are in storage in Louisville, Kentucky.

4. In preparation to respond to Plaintiff's Fifth Request for Production of Documents, I reviewed several selected months' internal reports summarizing Humana's long distance telephone usage. Based upon my analysis of those records, I have estimated that for the period 1984 through 1988, approximately fourteen million (14,000,000) long distance telephone calls were made from Humana's corporate offices in Louisville, Kentucky to locations in Kentucky and other states, including calls made to Humana Hospital-Sunrise and Humana Health Insurance of Nevada's market office located in Las Vegas, Nevada. Also, among that estimated total are long distance telephone calls that originated at Humana Hospital-Sunrise and Humana Health Insurance of Nevada's market office in Las Vegas, Nevada, to other locations in Nevada and to locations in other states,

including calls to the corporate offices of Humana Inc. in Louisville, Kentucky.

I hereby certify that the foregoing is true and accurate to the best of my knowledge, information and belief.

/s/ William E. Lawrence
William E. Lawrence.

[Letterhead of Humana Health Care Plans, Las Vegas, Nevada]

November 13, 1987

Mr. Robert Evans
Supervisor Life and Health
Department of Commerce
Insurance Division
201 South Fall Street
Carson City, Nevada 89710

Re: Transfer of claims processing and payment from Mutual Administrators to Humana Corporate Claims System, Louisville, Kentucky.

Dear Bob,

The primary purpose for the above transfer is to better serve the consumer by providing them the claims, utilization and trend reports on a regular basis. By providing these reports, it will enable the consumer to better manage health care costs and provide a review of when employees and dependents are using health care services. These kinds of reports currently are not able to be generated on a regular basis through Mutual Administrators, Inc. Also, this will enable Humana Health Insurance of Nevada, Inc. to better comply with the recent proposed legislation in reporting data on health costs to the Department. The following is an outline of notification and implementation:

1. Notification:
   (a) Effective data of termination of contract is December 1, 1987.
   (b) Mutual Administrators, Inc. will be notified in person with letter on November 19, 1987.
   (c) All accounts will be notified by mail (letter) November 19, 1987 by Humana Health Insurance of Nevada, Inc.

   (d) All brokers will be notified by mail (letter) November 19, 1987 by Humana Health Insurance of Nevada, Inc.
   (e) All providers will be notified by mail (letter) November 19, 1987 by Humana Health Insurance of Nevada, Inc.
   (f) Legal council has approved termination.

2. Responsibilities:
   (a) Mutual Administrators, Inc.
      (1) Through November 30, 1987, Mutual Administrators, Inc. will be responsible for all claims incurred and reported.*
      (2) Mutual Administrators, Inc. will be responsible for the runout.*
   (b) Humana Health Insurance of Nevada, Inc.
      (1) Currently Humana, in Las Vegas, has five customer service representatives, four trained and one to be trained by December 1, 1987.
      (2) Currently ten terminals with inquiry capabilities with wiring and equipment for an additional twelve stations, if necessary.
      (3) Additional personnel to be added as needed.
      (4) Twenty-four hour hot line service to Las Vegas office.
      (5) Seventeen lines available for consumer inquiries.
      (6) Additional 2400 square foot in current building for expansion.
      (7) An 800 number to Las Vegas office for customer service outside of Clark County.
      (8) Account will be set up at FIB in Nevada for claims payments.

---

* If Mutual Administrators, Inc. refuses to accommodate, Humana is prepared to assume the responsibility.

(c) Humana Corporate Claims - Louisville, Kentucky:
(1) Adjudicate and pay claims for Nevada.
(2) Produce cards - cards have been ordered (temporary cards for December 1, 1987 and new permanent cards by January 1, 1998.
(3) Plans loaded and tested successfully in Corporate system for implementation December 1, 1987 or earlier if necessary.
(4) An 800 number to Corporate customer service in addition to local customer service lines.
(5) Provide regular reports (see attached).
(6) Two Corporate claims managers will be in Las Vegas the week of November 9, 1987 for claims instruction and coordination.

b, if any other information is needed, please give me a call.

Sincerely,

/s/ John R. Egermayer
John R. Egermayer
Executive Director

JRE:dw

cc: Roger Collins
Larry Cash
Judy Zelinski
Joyce Anderson
Bruce McClure
Jerry McClellan
Joe Lawrence

AFFIDAVIT OF RUDOLPH KERRY WHALEN

STATE OF NEVADA)
) ss.
COUNTY OF CLARK)

RUDOLPH KERRY WHALEN, being first duly sworn, deposes and says:

1. I, Rudolph Kerry Whalen, am an adult and at all times relevant hereto was a resident of Riviera, Arizona.

2. This affidavit is offered on behalf of Plaintiffs in the matter of *Forsyth v. Humana, CV-S-89-249-PMP (LRL)*, in reference to Plaintiffs' Second Amended Complaint

3. In 1986 my wife was hospitalized at Humana Hospital-Sunrise in Las Vegas, Nevada. She was insured as my dependent pursuant to a policy of health insurance issued by Humana Insurance Co. of Nevada. Consequently I am a Plaintiff in this action.

4. In 1986 I placed telephone calls from my residence in Riviera, Arizona to the offices of Humana Hospital-Sunrise and Humana Insurance Co. of Nevada and/or its agent, Mutual Administrators, all of whom were located in Las Vegas, Nevada, concerning bills I had received from Humana Hospital-Sunrise for my wife's treatment there that Humana Insurance Co. of Nevada had delayed in paying, thereby causing Humana Hospital-Sunrise to demand that I pay those bills.

5. In 1987 my minor daughter was hospitalized at Humana Hospital-Sunrise in Las Vegas, Nevada. She was insured as my dependent pursuant to a policy of health insurance issued by Humana Insurance Co. of Nevada.

6. In 1987 I placed telephone calls from my residence in Riviera, Arizona to the offices of Humana Hospital-Sunrise and Humana Insurance Co. of Nevada and/or its agent,

Mutual Administrators, all of whom were located in Las Vegas, Nevada, concerning bills I had received from Humana Hospital-Sunrise for my daughter's treatment there that Humana Insurance Co. of Nevada had delayed in paying, thereby causing Humana Hospital-Sunrise to demand that I pay those bills.

7. At no time in the course of those telephone conversations in 1986 and 1987 did Humana Insurance Co. of Nevada and/or its agent, Mutual Administrators, ever inform me that Humana Insurance Co. of Nevada had entered into an agreement with Humana Hospital-Sunrise whereby Humana Hospital-Sunrise discounted the portion of those bills that Humana Insurance Co. of Nevada was obligated to pay, but not those portions of the bills that I was obligated to pay, and that Humana Insurance Co. of Nevada had not applied that discount to, or in any other manner reduced, the amount that I was obligated to pay.

DATED this 13th day of August, 1991.

/s/ Rudolph Kerry Whalen
RUDOLPH KERRY WHALEN

SUBSCRIBED and SWORN to before me this 13th day of August, 1991.

/s/ Janet L. Slone
NOTARY PUBLIC

[stamp—(SEAL)/Janet L. Slone/Notary Public-State of Nevada/
CLARK COUNTY/My Appointment Expires Jan. 14, 1994]

[Message Form—Tops Form 3002P]

IMPORTANT MESSAGE

FOR Herschell

DATE 5-2 TIME 11:20 A.M.

M John Andris

OF Humana (law Dept)

PHONE 502-580-3717

TELEPHONED ✓ PLEASE CALL ✓

MESSAGE Merger &
documents you
asked for regarding
exam

SIGNED SKK

[Letterhead of First Interstate Bank, Reno, Nevada]

March 9, 1984

Mr. David Reinhardt
Investment Management Department
Humana, Inc.
P. O. Box 1438
Louisville, Kentucky 40201

Dear Mr. Reinhardt:

Enclosed is the confirmation statement for the Treasury Bill purchased on March 2, 1984. Although the statement shows principal of $1,501,300.00, please let this letter confirm receipt from you for $1,501,355.63 by wire on March 2.

For your information, we have reserved a corporate demand account number 002-0011288 for Humana Health Insurance of Nevada, Inc. To complete required documentation, kindly fill in the items checked on the enclosed signature cards/ corporate resolution form and the taxpayer identification form, and return these at your earliest convenience.

We appreciate your selecting First Interstate Bank of Nevada, N.A. for your banking needs.

Sincerely,

/s/ Marvin M. Mann

MMM:aa

Enclosures

[Form AC-250T (0983), First Interstate Bank, Reno, NV]

Confirmation and Statement

Order No. 0011—T

We confirm according to the transaction code below and the terms stated hereon and the reverse side hereof. If this confirmation is not in all respects in accordance with your understanding, please notify us immediately.

Account Number (BLANK) Trade Date 3-1-84
Settlement Date 3-2-84 Security Number/Cusip (BLANK)

Humana Health Insurance
of Nevada, Inc.
C/O Marvin Mann

PRINCIPAL $1,501,350.00

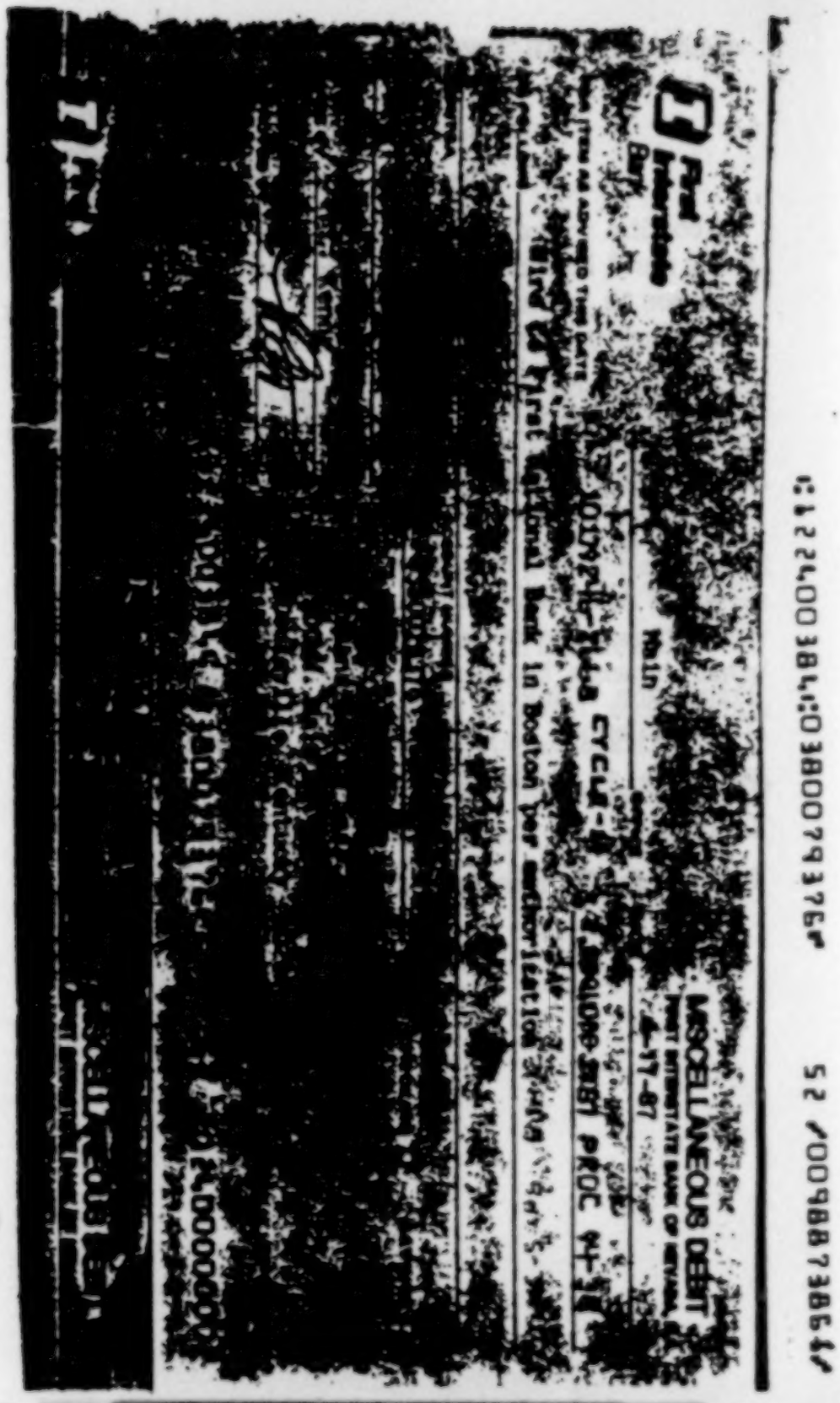
TOTAL AMOUNT DUE $1,501,350.00

Transaction X Sold Type I Tran Code 2
Trader/Salesman 2 Price 95,3238 Rate 9.30 Disc

Par Value $1,575,000.00 Yield 9.89

Description U.S. Treasury Bills Due 8-30-84

Payment and Delivery Instructions: Hold in Safekeeping



BEST AVAILABLE COPY

J. RANDALL JONES, ESQ.
WILL KEMP, ESQ.
JONES, JONES, CLOSE
& BROWN, CHARTERED
700 Valley Bank Plaza
300 South Fourth Street
Las Vegas, NV 89101-6026
Telephone: (702) 385-4202

ATTORNEYS FOR PLAINTIFFS

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO. CV-S-89-249-PMP (L.R.L.)

MARY FORSYTH, et. al.

Plaintiffs,

vs.

HUMANA, INC., et, al.

Defendants.

PLAINTIFFS' MOTION FOR LEAVE TO FILE REVISED THIRD AMENDED COMPLAINT AND JURY DEMAND

Plaintiffs, by and through their counsel of record, Jones, Jones, Close & Brown, Chartered, hereby file this Motion for Leave to File Revised Third Amended Complaint and Jury Demand. This Motion is based on Fed. R. Civ. P. 15, the pleadings and papers on file with the Court, and the points and authorities set forth herein. Plaintiffs have drastically altered their former proposed Third Amended Complaint, deleting all new parties and any new claims other than Plaintiffs' 18 U.S.C. § 1503 allegations. These measures should eliminate the concerns expressed by the Court in its Order of December 6, 1991.

POINTS AND AUTHORITIES

I

STATEMENT OF THE CASE

On March 29, 1989, Plaintiffs filed their initial Complaint in this matter. On April 28, 1989, Defendants filed a Motion to Dismiss that Complaint. On September 27, 1989, this Court entered an Order effectively denying Defendants' Motion to Dismiss. On October 27, 1989, Plaintiffs filed an Amended Complaint in response to the rulings in that Order. On January 18, 1990, Defendants filed a Second Motion to Dismiss. On July 9, 1991, this Court entered an Order effectively denying that Second Motion to Dismiss. In that Order the Court granted Plaintiffs leave to file a Second Amended Complaint, and on August 12, 1991, Plaintiffs filed their Second Amended Complaint. On September 4, 1991, Defendants filed their first Answer.

On October 31, 1991, Plaintiffs filed their Motion for Leave to File a Third Amended Complaint (Exhibit 1). On November 15, 1991, Defendants filed their Opposition to that Motion (Exhibit 2). On November 25, 1991, Plaintiffs filed their Reply to that Opposition (Exhibit 3). On December 6, 1991, the Court issued an Order denying Plaintiffs' Motion (Exhibit 4).

II

ARGUMENT

A. Plaintiffs' Revised Third Amended Complaint Remedies the Stated Concerns of This Court.

In its Order denying Plaintiffs' first Motion for Leave, the Court stated:

> [T]he Court finds that Plaintiffs have failed to demonstrate that the proposed additions to the complaint could not have been included in earlier amendments. Plaintiffs have had numerous opportunities to apprise Defendants and this Court of all purported grounds for relief and any additional parties they to bring before the Court.

Order at 1. That previous Third Amended Complaint contained the following new claims and parties:

a. Federal RICO violations of 18 U.S.C. 1962(d) conspiracy to violate 18 U.S.C. 1962(a);

b. Federal RICO violations relating to 18 U.S.C. § 1503.

c. Violations of the Nevada RICO statutes;

d. Violations by additional Co-Defendants Wendell Cherry and William Larry Cash.

In the revised Third Amended Complaint attached hereto, Plaintiffs have responded to this Court's concerns by removing from the earlier version all of those new claims other than (b). Plaintiffs have additionally deleted all new parties.[1]

The revised Third Amended Complaint preserves Plaintiffs' claims regarding violations of 18 U.S.C. § 1503, on the grounds that those claims arose in their entirety after Plaintiffs' filed their Second Amended Complaint, and consequently Plaintiffs had no prior opportunity whatsoever to apprise Defendants or this Court of those claims. Plaintiffs believe they are entitled to pursue those claims in the interests of fairness and justice, and that for reasons of

---

[1] The present Motion does not constitute a waiver or abandonment by Plaintiffs of the claims, allegations, positions and arguments set forth in their first Motion for Leave or in their Reply to Defendants' Opposition thereto, or in the Third Amended Complaint that accompanied that Motion. Plaintiffs expressly reserve the right to pursue those matters at other times and in other forums.

judicial economy those claims ought to be joined in the present litigation.

In all other respects the revised Third Amended Complaint, now less than one-half the length of its predecessor, contains only the technical modifications and clarifications that appeared therein.

Fed. R. Civ. P. 15(a) allows a party to apply for leave to amend a pleading, and provides that "leave shall be freely given when justice so requires." One authority has observed that "[s]ubdivision (a) encourages the court to look favorably on requests to amend . . . . This proposition has been reinforced by innumerable judicial pronouncements by the federal appellate and district courts alike." 6 Charles A. Wright, Arthur R. Miller, & Mary K. Kane, *Federal Practice and Procedure* § 1483 (1990). Most significantly, the United States Supreme Court declared in *Foman v. Davis*, 371 U.S. 178 (1962), that

> If the underlying facts or circumstances relied upon by a plaintiff may be a proper subject of relief, he ought to be afforded an opportunity to test his claim on the merits. In the absence of any apparent or declared reason . . . the leave sought should, as the rules require, be "freely given."

Id., 371 U.S. at 182.

B. Plaintiffs' Revised Third Amended Complaint Does Not Prejudice Defendants.

In its Order this Court expressed concern that Plaintiffs had earlier opportunities to add new parties and allege new claims, yet they had not done so. The Court did not indicate, however, that Defendants were thereby prejudiced. And in fact Plaintiffs were not prejudiced by that proposed Third Amended Complaint.

Mere delay, absent significant prejudice to the opposing party, is not legally adequate grounds for denying a motion to amend. "It should be emphasized . . . that while laches and unexpected delay may bar a proposed amendment, *delay alone, regardless of its length, is not enough to bar it if the other party is not prejudiced.*" 3 James W. Moore, Richard D. Freer, *Moore's Federal Practice* ¶ 15.08[4], at 15-76 (2d ed. 1991) (emphasis added). If that were not true, then any motion to amend filed after some indeterminate period of delay might be denied for that reason alone, effectively imposing a deadline on motions to amend. Nothing in the Federal Rules of Civil Procedure indicates its drafters intended a restriction of that sort.

The Ninth Circuit has consistently reaffirmed this principle. The leading decision is *Howey v. United States*, 481 F.2d 1187 (9th Cir. 1973). In *Howey* the Plaintiff had delayed for five years in filing its motion to amend. As in the present instance, the trial court had not found prejudice; it denied the motion entirely by reason of the delay in amending. On appeal, the Ninth Circuit reversed, stating: "The crucial factor is the resulting prejudice to the opposing party." *Id.* at 1190. "We discern from the record that the district judge placed great weight on delay as a factor in his decision. . . . [T]he mere fact that the [plaintiff] could have moved at an earlier time to amend does not by itself constitute an adequate basis for denying leave to amend." *Id.* at 1191.

> *[W]e know of no case where delay alone was deemed sufficient grounds to deny a Rule 15(a) motion to amend.* Where there is a lack of prejudice to the opposing party and the amended complaint is obviously not frivolous, or made as a dilatory maneuver in bad faith, *it is an abuse of discretion to deny such a motion.* The purpose of the litigation process is to vindicate meritorious claims. Refusing, solely because of delay, to

> permit an amendment to a pleading in order to state a potentially valid claim would hinder this purpose while not promoting any other sound judicial policy. Only where prejudice is shown or the movant acts in bad faith are courts protecting the judicial system or other litigants when they deny leave to amend a pleading.

Id. at 1190-91 (citations omitted) (emphasis added).

The Ninth Circuit held firm to that principle in *United States v. Webb*, 655 F.2d 977 (9th Cir. 1981) and *Hurn v. Retirement Fund Trust of Plumbing, Heating and Piping Indus. of S. Cal.*, 648 F.2d 1252 (9th Cir. 1981). In *Webb* the court issued its ringing declaration that

> In exercising [its] discretion, a court must be guided by the underlying purpose of Rule 15—to facilitate decision on the merits, rather than on the pleadings or technicalities. Accordingly, Rule 15's policy of favoring amendments to pleadings should be applied with "*extreme liberality*."

Id. at 979 (emphasis added) (citations omitted). The court then reaffirmed the holding in *Howey*, citing as well Professor Moore's treatise: "The mere fact that an amendment is offered late in the case is . . . not enough to bar it." *Id.* at 980 (citation omitted).

In *Sierra Club v. Union Oil Co. of Cal.*, 813 F.2d 1480 (9th Cir.), *vacated on other grounds*, 485 U.S. 931 (1987), the court relied once more on *Howey*, noting additionally that "where a defendant is on notice of the *facts* contained in an amendment to a complaint, there is no serious prejudice to defendant in allowing the amendment." *Id.* at 1493 (emphasis added). In both their former and revised Third Amended Complaints, Plaintiffs have not alleged any new *facts* other than those set forth in their § 1503 claims. In the

former version, Plaintiffs merely alleged new legal theories; in the revised version, Plaintiffs have not even done that.

The court in *Sierra Club* additionally stressed the policy reasons for liberally granting motions to amend:

> General considerations of judicial economy also justify allowing the amendments. The violations included in the proposed amendment relate to the same subject matter as the original complaint. Allowing the amendment will further the federal policy of "wrapping in one bundle all matters concerning the same subject matter."

Id. at 1493 (citation omitted).

And as recently as March of 1991 the Ninth Circuit reiterated, in *United States v. Pend Oreille Public Utility Dist. No. 1*, 926 F.2d 1502 (9th Cir. 1991), that "the crucial factor is not length of delay, but prejudice." *Id.* at 1511 (citing *Howey*, inter alia).

For the foregoing reasons, Plaintiffs request that this Court allow them to file their revised Third Amended Complaint, without the addition of any new parties or claims other than those relating to 18 U.S.C. § 1503. Plaintiffs believe Defendants cannot even arguably assert any prejudice that might arise from granting that request, and consequently this Court ought to grant it in accordance with the clear mandate of the Ninth Circuit as set forth herein.

DATED this 13th day of December, 1991.

Respectfully submitted,

JONES, JONES, CLOSE
& BROWN, CHARTERED

By /s/ J. Randall Jones
J. RANDALL JONES, ESQ.
JOHN W. FIELD, ESQ.
300 Valley Bank Plaza
300 South Fourth Street
Las Vegas, Nevada 89101

ATTORNEYS FOR PLAINTIFFS

RECEIPT OF COPY

RECEIPT of a true and correct copy of the attached PLAINTIFFS' MOTION FOR LEAVE TO FILE REVISED THIRD AMENDED COMPLAINT AND JURY DEMAND is hereby acknowledged this 13th day of December, 1991.

LIONEL SAWYER & COLLINS

By /s/ Louis E. Garfinkel
LOUIS E. GARFINKEL, ESQ.
1600 Valley Bank Plaza
300 South Fourth Street
Las Vegas, Nevada 89101

CERTIFICATE OF MAILING

I hereby certify that on the 13th day of December, 1991, the foregoing PLAINTIFFS' MOTION FOR LEAVE TO FILE REVISED THIRD AMENDED COMPLAINT AND JURY DEMAND was served on the following by mailing a copy thereof, first class mail, postage prepaid, to:

Mark J. Biros, Esq.
CASSON, HARKINS & LAPALLO
1233 20th Street, N.W., #800
Washington, D.C. 20036

/s/ Jill S. Fletcher
An employee of JONES, JONES, CLOSE &
BROWN, CHARTERED

J. RANDALL JONES, ESQ.
WILL KEMP, ESQ.
JONES, JONES, CLOSE
& BROWN, CHARTERED
700 Valley Bank Plaza
300 South Fourth Street
Las Vegas, NV 89101-6026
Telephone: (702) 385-4202

ATTORNEYS FOR PLAINTIFFS

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO. CV-S-89-249 PMP (L.R.L.)

MARY FORSYTH, et. al.

Plaintiffs,

vs.

HUMANA, INC., et, al.

Defendants.

ORDER

The Court having considered the arguments of counsel, and good cause appearing, it is hereby

ORDERED, that Plaintiffs may file their revised Third Amended Complaint.

DATED this ___ day of _____, 1991.

_____
UNITED STATES DISTRICT COURT JUDGE

Submitted By:

JONES, JONES, CLOSE
& BROWN, CHARTERED

By /s/ J. Randall Jones
J. RANDALL JONES, ESQ.
JOHN W. FIELD, ESQ.
700 Valley Bank Plaza
300 South Fourth Street
Las Vegas, Nevada 89101-6026

ATTORNEYS FOR PLAINTIFFS

J. RANDALL JONES, ESQ.
WILL KEMP, ESQ.
JONES, JONES, CLOSE
& BROWN, CHARTERED
700 Valley Bank Plaza
300 South Fourth Street
Las Vegas, NV 89101-6026
Telephone: (702) 385-4202

STANLEY M. CHESLEY, ESQ.
WAITE, SCHNEIDER, BAYLESS &
CHESLEY CO., L.P.A.
1515 Central Trust Tower
Fourth and Vine Streets
Cincinnati, OH 45202

JOHN L. CUMMINGS III, ESQ.
CUMMINGS, CUMMINGS & DUDENHEFER
416 Gravier Street
New Orleans, LA 70130

WENDELL GAUTHIER, ESQ.
GAUTHIER & MURPHY
3500 North Hullen Street
Metairie, LA 70002

ATTORNEYS FOR PLAINTIFFS

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO. CV-S-89-249-PMP (L.R.L.)

MARY FORSYTH; MARRIETTA CADE; WILLIE ANDREWS; MARY LOU BUEHLER; HELEN STAVES; RANDOLPH BRATTON; and SEARLE AUTO GLASS, INC., doing business as BEST GLASS COMPANY,

Plaintiffs,

vs.

HUMANA, INC., a Delaware corporation; HUMANA HEALTH INSURANCE OF NEVADA, INC., a Nevada corporation; and DOES I through X, inclusive,

Defendants.

THIRD AMENDED COMPLAINT AND JURY DEMAND

TABLE OF CONTENTS

I JURISDICTION AND VENUE 1

II RELEVANT TIMES 2

III PARTIES 2

IV FIRST CLAIM FOR RELIEF (Violations of ERISA) 6

A. Negotiation of the Secret Discount 6

B. Concealment of the Secret Discount 7

C. Failure to Disclose the Secret Discount 7

D. Submission of the Fraudulent Master Policy 7

E. Sale of the Fraudulent Group Policies 8

F. Promotion of the Fraudulent Group Policies 8

G. Failure to Pass Along Reduced Costs or Discounts 9

H. Failure to Accomplish Exclusive Purpose of Providing Benefits and Defraying Costs of Administration 9

I. Failure to Adhere to Documents and Instruments Governing the Plan 9

J. Failure to Discharge Duties with Diligence and Care 9

K. Dealing in a Fiduciary's Self-Interest 10

L. Acting on Behalf of an Adverse Party 10

M. Receiving Consideration for a Fiduciary's Own Account 10

N. Requested Relief 10

V SECOND CLAIM FOR RELIEF (Violations of Federal Antitrust Laws) 11

VI THIRD CLAIM FOR RELIEF (Violations of Federal Racketeering Laws) 16

A. General Allegations 16

B. Racketeering Activities 18

1. 18 U.S.C. § 1341 18

2. 18 U.S.C. § 1343 19

3. 18 U.S.C. § 1503 22

C. The RICO "Enterprise" 24

1. Humana as RICO "Enterprise" but not as RICO "Person" 25

2. Humana Insurance as RICO "Enterprise" but not as RICO "Person" 25

3. The "Humana Group" as RICO "Enterprise" 25

a. Membership of the Humana Group (26);

b. Purposes and Responsibilities of the Humana Group. (26);

c. Bases for the Humana Group (26);

d. Time Period of the Humana Group (27);

e. Culpability of the Humana Group (27)

D. Violations of 18 U.S.C. § 1962(c) 27

E. Violations of 18 U.S.C. § 1962(d) conspiracy to violate 18 U.S.C. § 1962(a) 28

F. Violations of 18 U.S.C. § 1962(d) conspiracy to violate 18 U.S.C. § 1962(c) 29

1. Conduct or participation in the affairs of the enterprise 29

2. Conduct or participation in a pattern of racketeering activity 29

G. Requested Relief 30

VIII PRAYER FOR RELIEF 30

Plaintiffs Mary Forsyth, Marrietta Cade, Willie Andrews, Mary Lou Buehler, Helen Staves, Randolph Bratton, and Searle Auto Glass, Inc., d/b/a Best Glass Co., by and through their counsel of record, J. Randall Jones and Will Kemp of Jones, Jones, Close & Brown, Chartered; Stanley M. Chesley of Waite, Schneider, Bayless & Chesley Co., L.P.A.; John L. Cummings III of Cummings, Cummings & Dudenhefer; and Wendell Gauthier of Gauthier & Murphy, for their causes of action against Defendants complain, aver, and allege as follows:

I

JURISDICTION AND VENUE

1. This action arises under the laws of the United States and includes claims for relief under 29 U.S.C. § 1001, et seq., the Employment Retirement Income Security Act ("ERISA"); these proceedings are also instituted against the above-named Defendants Humana, Inc. and Humana Health Insurance, Inc. under Sections 4 and 16 of the Clayton Act (15 U.S.C. §§ 15 and 26) to secure damages from and injunctive relief against Humana for its violations of Section 2 of the Sherman Act (15 U.S.C. § 2) as hereinafter alleged; these proceedings are also instituted under 18 U.S.C. §§ 1961 - 1968. Subject matter jurisdiction is conferred on this Court by 15 U.S.C. §§ 15 & 16, 18 U.S.C. § 1964(c), 28 U.S.C. § 1331, 28 U.S.C. § 1337, 28 U.S.C. § 1367, and 29 U.S.C. § 1132

2. Venue of this action is proper in this Court pursuant to 15 U.S.C. § 15, 18 U.S.C. § 1965, 28 U.S.C. § 1391, and 29 U.S.C. § 1132.

3. Defendants Humana and Humana Insurance maintain offices and transact business and may be found within the District of Nevada. The interstate trade and commerce involved and affected by the alleged violations of the

antitrust laws is carried on, in part, within the District of Nevada. These claims arose within the District of Nevada. It is in the ends of justice that other parties be brought before this Court.

II

RELEVANT TIMES

4. The period of time relevant to this Third Amended Complaint is from 1984 to the present. Within that relevant period, (a) the breaches of fiduciary duties by Defendant Humana Insurance continued from 1984 through at least 1989; (b) Defendants' monopolization or attempts to monopolize have continued from 1984 to the present; (c) Defendants' scheme to defraud and to obtain money by false pretenses continued from 1984 through at least 1989, (d) Defendants' pattern of racketeering activities have continued from 1984 to the present; and (e) the duration of each of the three enterprises described *infra* has continued from 1984 to the present. This Court has limited the period of recovery herein to that for Defendants' acts and events occurring during the period from 1985 through 1988, inclusive.

III

PARTIES

5. Plaintiff Mary Forsyth resides at 4625 East Twain Street, Las Vegas, Nevada 89121. In 1986 Ms. Forsyth was insured with Humana Care Plus through her employer, Kreel Printing. Ms. Forsyth paid a portion of the insurance premiums for her insurance with Defendant Humana Health Insurance of Nevada, Inc. ("Humana Insurance") through payroll deductions.

6. Plaintiff Marrietta Cade, 4433 West Lake Mead Boulevard, Las Vegas, Nevada has been insured with Humana

Insurance since 1985. Marrietta Cade worked for many years at the Las Vegas Sun. Mrs. Cade terminated her employment in December 1988. Mrs. Cade was at all times relevant Humana Insurance insured and currently remains personally insured with Humana Care Plus paying a monthly premium of approximately $355.00 per month. Her husband, Robert Cade, was a dependent under her Humana Insurance policy. Robert Cade was hospitalized at Humana Hospital-Sunrise between October 7, 1987 and October 17, 1987. The Cades incurred a hospital bill of $16,437.66. Mrs. Cade paid co-payments for her husband's hospitalization.

7. Plaintiff Willie Andrews, 804 McWilliams Street, Las Vegas, Nevada 89106, has been insured with Humana Care Plus since May 1985. At all times relevant, Ms. Andrews was employed with the Clark County School District and made premium payments through her employer. Ms. Andrews was hospitalized from November 4, 1986 through November 9, 1986. Pursuant to the 20% co-payment provisions, Ms. Andrews was obligated to pay and did pay a portion of all of her hospitalization costs.

8. Plaintiff Mary Lou Buehler, 210 Myers Avenue, Henderson, Nevada 89015, has been an insured with Humana Insurance since 1984. She is insured through her husband's employer, Cashman Cadillac. Through her husband, a dependent premium was paid of approximately $140.00 per month for her coverage. In September 1987 and again in October of 1988, Mrs. Buehler was hospitalized for a total of approximately fourteen days. Her charges for those hospitalizations were $23,293.94 and $2,736.85, respectively. Pursuant to the co-payment provision of her policy she was obligated to pay 20% of the costs of her hospitalization. Mrs. Buehler has paid a portion of the co-payment.

9. Plaintiff Helen Staves, HCR 65, Box 71408, Pahrump, Nevada 89041, has been insured with Humana Insurance since July 1988. At all times relevant, Ms. Staves was employed at the Dunes Hotel and made separate monthly premium payments of $40.00 per pay period for her policy of health insurance with Humana Insurance. In October 1988 Ms. Staves was hospitalized at Humana Hospital-Sunrise. Pursuant to the co-payment provisions under her policy, she was required to pay 20% of the costs of that hospitalization. Her expenses incurred for that hospitalization were $14,764.35. Ms. Staves paid her portion of the co-payment.

10. Plaintiff Randolph Bratton, P.O. Box 175, State Route 38, Las Vegas, Nevada 89124 has been insured with Humana Insurance since 1985. Between 1985 and August of 1987, Mr. Bratton was employed by the Las Vegas Sun. Since August 1987 Mr. Bratton has been employed by the Clark County School District. At all times relevant, Mr. Bratton was an insured of Humana Insurance. On February 12, 1988, Mr. Bratton was admitted to Humana Hospital-Sunrise. At that time day surgery was performed on Mr. Bratton and he incurred a hospital bill of approximately $1,400.00. Mr. Bratton remains obligated to make the 20% co-payment.

11. Plaintiff Searle Auto Glass, Inc., doing business as Best Glass Co. ("Best Glass"), 1225 S. Commerce Street, Las Vegas, Nevada 89102, is a Nevada corporation in good standing. Best Glass has used Humana Insurance to provide health insurance to its employees between the years 1985 and 1988, inclusive. Best Glass's group number with Humana Insurance was 82801-18351-001. When Best Glass first became an insured with Humana Insurance, its premiums were very reasonable: $64.23 per employee per billing period. In 1986 those premiums increased by 3 percent, and in 1987 by 13 percent. Finally, in 1988, when Best Glass

decided not to renew with Humana Insurance, Humana Insurance sought a premium increase of 41 percent to continue coverage of employees of Best Glass.

12. Defendants did not inform individual Plaintiffs or Best Glass that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those Plaintiffs at Humana-Sunrise.

13. Defendant Humana Health Insurance of Nevada, Inc. ("Humana Insurance") is a corporation organized and existing under the laws of the State of Nevada with its principal place of business in Las Vegas, Nevada. Humana Insurance is a wholly-owned subsidiary of Humana through Humana's ownership of Group Health Insurance, Inc. ("Group Health"). Humana Insurance markets and sells group health insurance through employee benefit plans to employers throughout the State of Nevada, but with its principal geographic market being the Southern Nevada market, an area that includes portions of Southern California, Arizona, and Utah.

14. Defendant Humana, Inc. ("Humana") is a corporation organized and existing under the laws of the State of Delaware, with its principal place of business in Louisville, Kentucky. Humana is, and has been for many years, one of the largest owners and operators of acute-care hospitals in the United States. It owned and operated approximately 87 hospitals and health care facilities in 1986, one of which was Humana Hospital-Sunrise ("Humana-Sunrise") in Las Vegas, Nevada. Although Humana-Sunrise was only one of Humana's 87 hospitals in 1986, according to Humana's 1986 report to stockholders, Humana-Sunrise generated 6.6 percent of Humana's gross revenue; and according to documents filed with the Nevada Department of Humana

Resources in 1986, Humana-Sunrise generated 38 percent of Humana's pretax profits.

15. The true names and capacities, whether individual, corporate, associate, or otherwise, of Defendants herein designated as DOES I through X, inclusive, are not known to Plaintiffs at this time, who therefore sue those Defendants by fictitious names. Each of those Defendants is responsible in some manner for the events and happenings and proximately caused the injuries and damages herein alleged. Plaintiffs will request leave to amend this Complaint to allege the true names and capacities of those Defendants when and as Plaintiffs ascertain them.

16. By order of this Court on September 26, 1989, Plaintiffs Willie Andrews, Randolph Bratton, Marrietta Cade, Mary Lou Buehler, and Helen Staves (the "Co-Payor Class") were recognized as class representatives pursuant to Fed. R. Civ. P. 23(b)(3). This class consists of individuals who incurred charges at Humana-Sunrise and who overpaid some portion of their co-payments during the relevant times.

17. By order of this Court on September 26, 1989, certain Plaintiffs (the "Antitrust Premium-Payor Class") were recognized as class representatives pursuant to Fed. R. Civ. P. 23(b)(3). This class consists of individuals or entities who paid all or a portion of the Humana Insurance premiums during the relevant times.

18. By order of this Court on July 9, 1991, Plaintiffs Mary Forsyth, Marrietta Cade, Willie Andrews, Helen Staves, and Best Glass (the "Antitrust Co-Payor Class") were recognized as class representatives pursuant to Fed. R. Civ. P. 23(b)(3). This class consists of individuals who incurred charges at Humana-Sunrise and who overpaid some portion of their co-payments during the relevant times.

19. By order of this Court on July 9, 1991, Plaintiffs Mary Forsyth, Marrietta Cade, Willie Andrews, Mary Lou Buehler, Helen Staves, Randolph Bratton, and Best Glass (the "RICO Premium-Payor Class") were recognized as class representatives pursuant to Fed. R. Civ. P. 23(b)(3). This class consists of individuals or entities who paid all or a portion of the Humana Insurance premiums during the relevant times.

20. By order of this Court on July 9, 1991, Plaintiffs Marietta Cade, Willie Andrews, Mary Lou Buehler, Helen Staves, and Randolph Bratton (the "RICO Co-Payor Class") were recognized as class representatives pursuant to Fed. R. Civ. P. 23(b)(3). This class consists of individuals who incurred charges at Humana-Sunrise and who overpaid some portion of their co-payments during the relevant times.

CLASS ACTION

IV

FIRST CLAIM FOR RELIEF

(Violations of ERISA)

21. The Co-Payor Class reasserts and realleges each and every allegation contained in paragraphs 1 through 22 of this Third Amended Complaint as though fully set forth at this point.

22. The Co-Payor Class consists of employees obtaining health insurance benefits under an employee benefit plan as defined under 29 U.S.C. 1001, et seq.

23. The members of the Co-Payor Class incurred charges at Humana-Sunrise for hospitalization and were obligated to or did pay a portion of the hospital charges. Defendant Humana Insurance was the insurer of the members of the Co-Payor Class through its group health insurance plan, Humana Care Plus.

A. Negotiation of the Secret Discount

24. On or about April 24, 1984, Humana and Humana Insurance negotiated a secret agreement that greatly reduced or discounted hospital charges for Humana Insurance patients incurring charges at Humana-Sunrise. Humana Insurance thereby exercised discretionary authority and discretionary control respecting management of the group health insurance plan, discretionary authority and discretionary control respecting management or disposition of assets of the plan, and discretionary authority or discretionary responsibility in the administration of the plan. Consequently Humana Insurance was a fiduciary as defined under 29 U.S.C. § 1001(21)(A).

25. The aforementioned secret agreement between Humana and Humana Insurance specifically provided that Humana-Sunrise agreed to accept as payment in full for treatment of insureds at Humana-Sunrise amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services.

B. Concealment of the Secret Discount

26. During the years 1985 and 1986 Humana Insurance actively concealed from Plaintiffs that Humana-Sunrise had agreed to accept as payment in full for treatment of those insureds at Humana-Sunrise amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

C. Failure to Disclose the Secret Discount

27. During the years 1985 and 1986 Humana Insurance failed to disclose to Plaintiffs, and failed to take any action to inform Plaintiffs, that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise.

D. Submission of the Fraudulent Master Policy

28. In 1984 Humana Insurance submitted for approval to the Insurance Division of Nevada a master policy of group health insurance. That master policy set forth terms, conditions, and representations that were to appear in all policies of group health insurance that Humana Insurance sought to market in Nevada, and was approved for that purpose by the Insurance Division of Nevada.

29. The aforementioned master policy, and the Humana Care Plus policies that conformed thereto, failed to disclose to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to those insureds the savings that Humana Insurance obtained by negotiating a discount on those charges.

30. The Humana Care Plus policies required that each member of the Co-Payor Class pay 20% of the charges for medical treatment at Humana-Sunrise. Humana Insurance agreed to pay the remaining 80% of those charges. The members of the Co-Payor Class believed, and their agreements with Humana Insurance provided, that the members of the Co-Payor Class and Humana Insurance would be paying their respective contractual percentages of the charges.

E. Sale of the Fraudulent Group Policies

31. During the period from 1984 through 1988 Defendant Humana Insurance sold policies of group health insurance that conformed to the aforementioned master policy.

F. Promotion of the Fraudulent Group Policies

32. Humana Insurance advertised its policies of group health insurance during the period from 1984 through 1988 and stated in those advertisements that Humana Insurance had reduced the costs of providing medical treatment and was passing along those savings to its insureds. In those advertisements Humana Insurance did not inform insureds that Humana Insurance was not passing along to them the savings it obtained by negotiating a discount on the charges for treatment of those insureds at Humana-Sunrise.

33. Humana Insurance sales personnel did not inform insureds that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those insureds at Humana-Sunrise.

G. Failure to Pass Along Reduced Costs or Discounts

34. Defendant Humana Insurance breached its fiduciary duties to all members of the Co-Payor Class during the

period from 1984 through 1988 in they failed to pass along to insureds, in the form of reduced co-payments, the reduced costs or discounts that Humana Insurance was able to negotiate with Humana, in violation of 29 U.S.C. § 1004.

H. Failure to Accomplish Exclusive Purpose of Providing Benefits and Defraying Costs of Administration

35. Defendant Humana Insurance breached its fiduciary duties to all members of the Co-Payor Class during the period from 1984 through 1988 by failing to accomplish the exclusive purpose of providing benefits to participants and by failing to defray the reasonable expenses necessary for the administration of the plan. Humana Insurance imprudently decided to retain the co-payment refunds that Humana Insurance negotiated with Humana. Humana Insurance received excessive compensation in violation of its fiduciary duties pursuant to 29 U.S.C. § 1104.

I. Failure to Adhere to Documents and Instruments Governing the Plan

36. Defendant Humana Insurance breached its fiduciary duties to all members of the Co-Payor Class during the period from 1984 through 1988 by failing to adhere to the documents and instruments governing the plan, including without limitation Nevada Assembly Bills 278 and 289, and 29 U.S.C. § 1104.

J. Failure to Discharge Duties With Diligence and Care

37. Defendant Humana Insurance breached its fiduciary duties to all members of the Co-Payor Class during the period from 1984 through 1988 by failing to discharge those duties with respect to the plan with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use the conduct of an enterprise of a like character and with like aims.

K. Dealing in a Fiduciary's Self-Interest

38. Defendant Humana Insurance engaged in prohibited transactions in violation of its fiduciary duties during the period from 1984 through 1988 by dealing with the assets of the plan in Humana Insurance's own interest or for its own account, in violation of 29 U.S.C. § 1106.

L. Acting on Behalf of an Adverse Party

39. Defendant Humana Insurance engaged in prohibited transactions in violation of its fiduciary duties during the period from 1984 through 1988 by acting on behalf of Humana, whose interests are adverse to the interests of the plan or the Co-Payor Class. Humana Insurance was prohibited from even negotiating the co-payment amount with its related entity Humana, in violation of 29 U.S.C. § 1106.

M. Receiving Consideration for a Fiduciary's Own Account

40. Defendant Humana Insurance engaged in prohibited transactions in violation of its fiduciary duties during the period from 1984 through 1988 by unlawfully receiving consideration for Humana Insurance's own personal account in connection with a transaction involving the assets of the plan, in violation of 29 U.S.C. § 1106.

N. Requested Relief

41. It would be wrongful for Humana Insurance to retain monies, in excess of those it might otherwise have been entitled to, when such monies have been obtained wrongfully and in breach of the duties of Humana Insurance to the Co-Payor Class and of Humana Insurance's agreement with the Co-Payor Class.

42. A constructive trust should be imposed on Defendants that requires surrender of all monies obtained through the scheme described herein.

43. Plaintiffs should be named the beneficiaries of the constructive trust awarded by this Court.

44. As a result of Defendants' unlawful and/or inequitable scheme heretofore alleged, Plaintiffs have conferred a monetary benefit on Defendant Humana Insurance. Defendant Humana Insurance appreciated and realized the monetary benefit and accepted and retained the monetary benefit under circumstances such that it would be inequitable for Humana Insurance to retain the monetary benefit without returning the benefit to the Co-Payor Class. As a result of the scheme, Defendant Humana Insurance was unjustly enriched, all to the detriment of the Co-Payor Class.

45. The acts and practices of Defendants as set forth and described herein are reasonably likely to continue in the future and cause further injury and damage to Plaintiffs unless restrained by order of this Court, and therefore the Co-Payor Class is entitled to a permanent injunction against Humana Insurance.

46. The Co-Payor Class has been damaged as a result of the breach of ERISA fiduciary duties by Humana Insurance, and it is estimated that the approximate actual damages are in excess of $84,520,143.00.

47. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered; Waite, Schneider, Bayless & Chesley Co., L.P.A.; Cummings, Cummings & Dudenhefer; and Gauthier & Murphy to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor. 29 U.S.C. § 1132(g).

V

SECOND CLAIM FOR RELIEF

(Violations of Federal Antitrust Laws)

48. Plaintiffs reassert and reallege each and every allegation contained in paragraphs 1 through 140 of this Third Amended Complaint as though fully set forth at this point.

49. The Antitrust Premium-Payer Class consists of individuals or entities paying all or a portion of the Humana Insurance premiums during the period from 1985 through 1988, including without limitation employers who made insurance premium payments on behalf of their employees, as well as individual employees who either directly paid insurance premiums on behalf of their dependents, or who did so indirectly by such means as payroll deductions by their employers.

50. Defendant Humana is in the business of owning and operating for-profit acute-care health facilities. Humana owns and operates a for-profit acute-care health care facility named Humana Hospital-Sunrise which provides hospital services in Las Vegas, Nevada.

51. Defendant Humana is also in the business of owning and operating group health care insurance companies, and in 1984 established one such company, Humana Insurance, with its principal place of business in Nevada.

52. The relevant geographic market for antitrust purposes is Clark County, Nevada or a portion thereof.

53. The relevant product market affected by Defendants' conduct is the sale of general, non-specialty, for-profit, acute-care hospital services or a portion thereof, and the group health insurance or health care financing market or a portion thereof.

54. Humana-Sunrise has possessed and exercised market power in the relevant geographic market during the class period. One indication of Humana-Sunrise's market power is its ability consistently to generate profit levels far above competitive levels found in comparable geographic markets, or as compared to national averages, or as compared to Humana hospitals located in other states. In addition to exercising this power within the market for the sale of general, non-specialty, for-profit, acute-care hospital services, the market power of Humana-Sunrise is heightened within relevant submarkets that may include only privately-owned hospitals, or other submarkets that focus on particular hospital products or services, especially as those products or services are obtained by private insureds.

55. Since at least 1984, and to and including the date of the filing of this Complaint, Humana and Humana Insurance have violated Section 2 of the Sherman Act (15 U.S.C. § 2) by monopolizing and attempting to monopolize the above-described markets and/or submarkets.

56. In furtherance of the aforesaid monopolization and attempt to monopolize, Defendants formed a symbiotic relationship between Humana-Sunrise and Humana Insurance, with Humana Insurance acting as a feeder mechanism to funnel Humana Insurance insureds into Humana-Sunrise, where those insureds became members of the Antitrust Co-Payor Class. Defendants established and maintained that relationship with the express purpose and effect of maintaining or enhancing the market power of Humana-Sunrise.

57. Humana and Humana Insurance engaged in a scheme that consisted of numerous actions, the primary purpose and effect of which was to maintain or enhance the market power of Humana-Sunrise.

58. As part of the aforementioned scheme, Humana-Sunrise Hospital and Humana Insurance entered into a secret

discount arrangement. Humana and Humana Insurance did not offer that discount arrangement to other insurance companies or to other general, non-specialty, for-profit, acute-care hospitals in the relevant geographic market, did not include Humana Insurance co-payers in that discount arrangement, and did not pass along to Humana Insurance co-payors the savings that Humana Insurance obtained from that discount arrangement. That discount arrangement additionally allowed Humana-Sunrise to conceal illegal profits.

59. As part of the aforementioned scheme, Humana and Humana Insurance prepared and disseminated, or caused to be prepared and disseminated, advertisements that stated Humana Insurance was passing along savings to its insureds, yet failed to disclose to those insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Those advertisements conferred an unfair competitive advantage on Defendants.

60. As part of the aforementioned scheme, Humana Insurance sales personnel did not inform insureds that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those Plaintiffs at Humana-Sunrise.

61. As part of the aforementioned scheme, Humana and Humana Insurance hospital engaged in additional actions, including without limitation the following:

A. Defendants promoted the use of services offered by Humana-Sunrise and discouraged the use of services offered by other general, non-specialty, for-profit, acute-care hospitals through Humana Insurance policies, by requiring extensive penalties for insureds who obtained services from general, non-specialty, for-profit, acute-care hospitals other than Humana-Sunrise. Those penalties included without limitation the following:

1. Requiring a different and punitive deductible for obtaining services from general, non-specialty, for-profit, acute-care hospitals other than Humana-Sunrise;

2. Requiring a different and punitive co-payment for obtaining services from general, non-specialty, for-profit, acute-care hospitals other than Humana-Sunrise;

3. Applying a different standard of review when evaluating and paying claims from general, non-specialty, for-profit, acute-care hospitals other than Humana-Sunrise.

B. Humana engaged in a pattern of predatory pricing by offering Humana Insurance an unreasonable discount, while not offering that discount to other group health insurers in the relevant geographic market, nor to members of the Antitrust Co-Payor Class;

C. Humana Insurance required premiums for group health insurance policies that were anti-competitively high in comparison to premiums charged for comparable insurance by other group health care insurers in comparable geographic markets;

D. Humana Insurance initially engaged in predatory pricing within the relevant geographic market by attempting to undercut the premiums required for comparable insurance by other group health insurers in that market.

E. Humana Insurance required premiums for group health insurance policies that were far higher than those that normal actuarial practices would have indicated were reasonable for the percentages and amounts of co-payments of Humana-Sunrise's actual charges that members of the Antitrust Co-Payor Class paid.

62. The aforementioned scheme created misinformation among employers, insureds, and other third-party payers regarding hospital per diem arrangements and maximum potential discounts, thereby blunting competitive forces and allowing Humana-Sunrise to charge higher prices and offer less discounts than it could have without the scheme. In addition, because Humana Insurance misrepresented the risk-sharing provisions of its group health insurance plan, the premiums that Humana Insurance charged were artificially high, notwithstanding that at times those premiums may have been priced nominally lower than the premiums of comparable policies within the Clark County, Nevada area.

63. As a direct and proximate result of Defendants' market position and power, of their specific intent to maintain or enhance that market power, and of their actions to maintain or enhance that market power with a dangerous probability of success, the members of both the Antitrust Premium-Payor Class and the Antitrust Co-Payor Class incurred antitrust injuries and damages. The members of the Antitrust Premium-Payor Class incurred antitrust injuries and damages in that they were required to pay premiums for Humana Insurance policies that were high in comparison to what competitive rates would have been in the absence of Humana's market power. The members of the Antitrust Co-Payor Class incurred antitrust injuries and damages in that

they were required to pay co-payments for Humana-Sunrise services that were high in comparison to what competitive rates would have been in the absence of Humana's market power.

64. Plaintiffs estimate that the approximate actual damages of the Antitrust Premium-Payor Class and the Antitrust Co-Payor Class are in excess of $181,034,570.00, the principal of which is subject to trebling.

65. The anticompetitive acts and practices of Humana and Humana Insurance as set forth and described herein are reasonably likely to continue in the future and to cause further injury and damage to Plaintiffs unless restrained by order of this Court.

VI

THIRD CLAIM FOR RELIEF

(Violations of Federal Racketeering Laws)

A. General Allegations

66. Plaintiffs reassert and reallege each and every allegation contained in paragraphs 1 through 158 of this Third Amended Complaint as though fully set forth at this point.

67. Each Plaintiff and each member of the designated class that Plaintiffs represent is a "person" within the meaning of 18 U.S.C. § 1961(3) and § 1964(c).

68. With respect to their activities alleged herein, Defendants acted at all times with malice, intent, and knowledge, and with a wanton and reckless disregard for the rights of Plaintiffs.

69. With respect to the activities alleged herein, each Defendant aided and abetted each other Defendant, and others not presently known to Plaintiffs, in committing those activities, all in violation of the statutes set forth herein, and

specifically in violation of 18 U.S.C. § 2. Each Defendant agreed to the operation of the scheme to defraud and to obtain money by false pretenses.

70. With respect to the activities alleged herein, other than those involving violations of 18 U.S.C. 1962(d), each Defendant conspired with each other Defendant, and with others not presently known to Plaintiffs, in committing those activities, all in violation of the statutes set forth herein, and specifically in violation of 18 U.S.C. § 1962(d). Each Defendant agreed to the conspiracy to defraud and to obtain money by false pretenses.

71. As part of a scheme to defraud Plaintiffs and to obtain money from Plaintiffs by false pretenses, by charging Plaintiffs a different per diem per patient day on their co-payments, Humana and Humana Insurance entered into a secret agreement (the "Agreement") whereby Humana-Sunrise agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and whereby Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services. Humana Insurance did not discount the portion of those charges paid by Plaintiffs but based them instead on the usual and customary rate.

72. Humana Insurance did not reduce premiums in the amount discounted. As a part of the scheme to defraud and to obtain money by false pretenses, Humana, and/or Humana Insurance used false and fraudulent pretenses, representations, and promises calculated to deceive persons of ordinary prudence and due care, and concealed and made material nondisclosures of facts and information important to the insureds, including without limitation the existence of the secret agreement and that Humana was billing Humana

Insurance at a different per diem, all so as to unlawfully, intentionally, and willfully, and with the intent to defraud, that is, knowingly and with specific intent to deceive in order to cause financial gain to themselves, procure secret profits to the use and benefit of themselves and others and to the detriment of the insureds consisting of the named Plaintiffs, as representatives of a class pursuant to Fed. R. Civ. P. 23.

73. The scheme to defraud and to obtain money by false pretenses evolved over time a pattern of illegal activity that inflicted discrete harms on the insureds and others. The insureds, as victims of the unlawful patterns of illegal activity, also suffered discrete losses as a result of these activities. The multifarious illegal activities through which Humana and Humana Insurance carried out their broad objectives consisted of a complex pattern of individual transactions and group transactions.

74. As part of the scheme to defraud and to obtain money by false pretenses, Humana Insurance sales personnel did not inform insureds that Humana Insurance was not passing along to them the savings that Humana Insurance obtained by negotiating a discount on the charges for treatment of those Plaintiffs at Humana-Sunrise.

75. As a part of the scheme to defraud and to obtain money by false pretenses, Humana and Humana Insurance prepared and disseminated, or caused to be prepared and disseminated, false, misleading, and fraudulent advertisements that stated Humana Insurance was passing along savings to its insureds, yet failed to disclose to those insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or

discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Those advertisements conferred a fraudulently unfair competitive advantage on Defendants.

B. Racketeering Activities

76. In carrying out the scheme to defraud and to obtain money by false pretenses, Defendants Humana and/or Humana Insurance engaged in, *inter alia*, conduct in violation of federal laws, viz., 18 U.S.C. § 1341, 18 U.S.C. § 1343, and 18 U.S.C. § 1503, as stated below:

1. 18 U.S.C. § 1341.

77. For the purpose of executing and/or attempting to execute the scheme to defraud and to obtain money by means of false or fraudulent pretenses, representations, or promises, Defendants Humana and/or Humana Insurance placed in post offices, and/or in authorized repositories for mail matter, matters and things to be sent or delivered by the Postal Service, and received matters and things therefrom, and knowingly caused to be delivered by mail those matters and things according to the directions thereon or at the place at which they were directed to be delivered by the persons to whom they were addressed, including without limitation as set forth in Appendix 1.

(1) In those matters and things Defendants Humana and/or Humana Insurance falsely and fraudulently represented to insureds as charges for medical treatment amounts that were far greater than the amounts that Humana-Sunrise had agreed with Humana Insurance to accept as payment in full for that medical treatment. Humana and/or Humana Insurance intentionally and

knowingly made those material misrepresentations to insureds for the purpose of deceiving them and thereby obtaining financial gain. The insureds reasonably relied on those misrepresentations.

(2) In those matters and things Defendants Humana and/or Humana Insurance falsely and fraudulently failed to disclose to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Humana and/or Humana Insurance intentionally and knowingly failed to disclose that information to insureds for the purpose of deceiving them and thereby obtaining financial gain. The insureds reasonably relied on those nondisclosures.

Each such use of the mail during and in furtherance of the scheme to defraud and to obtain money by false pretenses violated 18 U.S.C. § 2 and 18 U.S.C. § 1341.

2. 18 U.S.C. § 1343.

78. For the purpose of executing and/or attempting to execute the scheme to defraud and to obtain money by means of false pretenses, representations, and promises, Defendants Humana and/or Humana Insurance transmitted or caused to be transmitted in interstate commerce wire,

radio, and television transmissions, including without limitation as set forth in Appendix 2.

A. Defendants sent, or caused to be sent, interstate radio and television advertisements promoting the Humana Insurance group health insurance plan. Those radio and television advertisements were broadcast from locations in Nevada across state borders to persons located in Arizona and/or Utah. In those advertisements Defendants Humana and/or Humana Insurance never disclosed to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Those advertisements conferred a fraudulently unfair competitive advantage on Defendants. Defendants Humana and/or Humana Insurance intentionally and knowingly failed to disclose that information to insureds for the purpose of deceiving them and thereby obtaining financial gain in the form, inter alia, of a fraudulently unfair competitive advantage. The insureds reasonably relied on those nondisclosures.

B. Defendants used the interstate telephone lines to explain or discuss billings in order to collect co-payments from insureds for hospital charges incurred at Humana-Sunrise. Defendants maintained offices both in Las Vegas, Nevada and in Louisville, Kentucky. Defendants engaged in telephone conversations from their Nevada offices with Plaintiffs located in other

states, including without limitation Arizona, California, and Utah, and from their Kentucky offices with Plaintiffs located in other states, including without limitation Arizona, California, Nevada, and Utah. In those telephone conversations Defendants Humana and/or Humana Insurance falsely and fraudulently represented to insureds as charges for medical treatment amounts that were far greater than the amounts that Humana-Sunrise had agreed with Humana Insurance to accept as payment in full for that medical treatment. Defendants Humana and/or Humana Insurance intentionally and knowingly made those material misrepresentations to insureds for the purpose of deceiving them and thereby obtaining financial gain. The insureds reasonably relied on those misrepresentations. Additionally, Defendants Humana and/or Humana Insurance failed to disclose to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Defendants Humana and/or Humana Insurance intentionally and knowingly failed to disclose that information to insureds for the purpose of deceiving them and thereby obtaining financial gain. The insureds reasonably relied on those nondisclosures.

C. On or about December 1, 1987, Defendants established a Louisville Claims Center in Louisville, Kentucky and a toll-free telephone line to that office for the

specific purpose of handling claims from corporate Plaintiffs located in Nevada. Defendants engaged in telephone conversations from their Kentucky offices with corporate Plaintiffs located in Nevada. In those telephone conversations Defendants Humana and/or Humana Insurance falsely and fraudulently represented to insureds as charges for medical treatment amounts that were far greater than the amounts that Humana-Sunrise had agreed with Humana Insurance to accept as payment in full for that medical treatment. Defendants Humana and/or Humana Insurance intentionally and knowingly made those material misrepresentations to insureds for the purpose of deceiving them and thereby obtaining financial gain. The insureds reasonably relied on those misrepresentations. Additionally, Defendants Humana and/or Humana Insurance failed to disclose to insureds that Humana-Sunrise had agreed to accept as payment in full, for treatment at Humana-Sunrise of persons insured by Humana Insurance, amounts that were far lower than the amounts that Humana stated it charged for those services, and that Humana-Sunrise was not to apply any reduction or discount to the charges it billed insureds for those services; and that Humana Insurance was not passing along to insureds the savings that Humana Insurance obtained by negotiating a discount on those charges for treatment of those insureds at Humana-Sunrise. Defendants Humana and/or Humana Insurance intentionally and knowingly failed to disclose that information to insureds for the purpose of deceiving them and thereby obtaining financial gain. The insureds reasonably relied on those nondisclosures.

D. Defendants engaged in telephone conversations from their offices in Louisville, Kentucky with persons in Nevada in the offices of the government of the State

of Nevada for the purpose of executing and/or attempting to execute Defendants' scheme to defraud and to obtain money by false pretenses.

E. Defendants have certified that during the period from 1984 through 1988, they engaged in an estimated 14,000,000 interstate telephone conversations. Those telephone conversations were in support of the scheme to defraud and to obtain money by false pretenses.

F. Humana, Inc. and/or Humana Insurance transferred millions of dollars by wire transfer from Nevada to other states and from other states to Nevada for the purpose of executing and/or attempting to execute Defendants' scheme to defraud and to obtain money by false pretenses, including without limitation as set forth in Appendix 2. Those interstate transfers of funds were in support of the scheme to defraud and to obtain money by false pretenses.

Each such use of interstate wire transmissions during and in furtherance of the scheme to defraud and to obtain money by means of false pretenses violated 18 U.S.C. § 2 and 18 U.S.C. § 1343.

3. 18 U.S.C. § 1503.

79. As part of the scheme to defraud and to obtain money by means of false pretenses, Defendants Humana and/or Humana Insurance corruptly influenced, obstructed, and impeded, or endeavored to influence, obstruct, and impede, the due administration of justice, including without limitation:

A. Humana and Humana Insurance concealed from Plaintiffs 930 boxes or more of documents relevant to this litigation. Defendants' concealment of those 930 or more boxes of documents resulted in the improper suppression of evidence. Defendants concealed those

930 boxes or more of documents by multiple acts and omissions, including without limitation:

1. Defendants signed and served on Plaintiffs false responses to requests for production that Plaintiffs had issued to Defendants. In those responses Defendants failed to inform Plaintiffs of the aforementioned 930 boxes or more of documents that were responsive to Plaintiffs' requests, and Defendants failed to produce those 930 boxes or more of documents.

2. On or about August 30, 1991, Defendants falsely testified, in the sworn deposition of Defendants' counsel John Andris, that Defendants possessed none of the written documents contained in the aforementioned 930 boxes or more.

3. On or about September 4, 1991, Defendants falsely informed Plaintiffs that the only one to obtain the information that was in fact contained in the aforementioned 930 boxes or more of documents was by retrieving it from computer records at a cost of $200,000 to Plaintiffs.

Defendants in fact knew they were in possession of those 930 boxes or more of documents and that those documents were responsive to Plaintiffs' requests for production. Defendants deliberately and willfully concealed that evidence from Plaintiffs, and consequently Defendants acted with the purpose of influencing, obstructing, and impeding the due administration of justice;

B. On or about January 18, 1990, Defendants signed, filed with this Court, and served on Plaintiffs a Second Motion to Dismiss, and on or about April 10, 1990, Defendants signed, filed with this Court, and served on

Plaintiffs a Reply to Plaintiffs' Opposition thereto, wherein Defendants falsely indicated they had not engaged in interstate wire communications. Defendants in fact knew they had engaged in more than 14,000,000 interstate telephone communications and numerous interstate wire transfers of funds. Defendants deliberately and willfully concealed that evidence from Plaintiffs, and consequently Defendants acted with the purpose of influencing, obstructing, and impeding the due administration of justice.

C. On or about August 30, 1991, Defendants falsely testified, in the sworn deposition of Defendants' Director of Underwriting, James W. Keene, that Defendants had never maintained a "Jeopardy Committee." Keene in fact knew that Defendants had maintained a Jeopardy Committee over a period of several years, that he had routinely communicated with members of that committee, and that the committee had generated numerous documents and records. The significance of Defendants' Jeopardy Committee is that it was authorized to reduce premiums for group health insurance below the levels dictated by normal actuarial principles, and in flagrant disregard of the rating methodology that Humana Insurance represented to the Insurance Division of Nevada as determining the premiums that Humana Insurance charged. The intervention of the Jeopardy Committee thereby allowed Humana Insurance to sell or renew policies of group health insurance that Humana Insurance was otherwise in jeopardy of not selling or renewing. In addition, the intervention allowed Humana Insurance to set premiums so low that Humana Insurance operated at a loss, in violation of Nevada insurance regulations.

Each such act or omission to corruptly influence, obstruct, and impede, or endeavor to influence, obstruct, and impede,

the due administration of justice violated 18 U.S.C. § 2 and 18 U.S.C. § 1503.

80. At all times when Defendants Humana and/or Humana Insurance corruptly influenced, obstructed, and impeded, or endeavored to influence, obstruct, and impede, the due administration of justice, this litigation was a pending judicial proceeding, and consequently this Court was engaged in the due administration of justice.

C. The RICO "Enterprise"

81. Plaintiffs allege three alternative "enterprises" within the meaning of 18 U.S.C. § 1961(4), § 1962(a), and § 1962(c), and, with respect to each of those alternatives, an alternative "person" or "persons" within the meaning of 18 U.S.C. § 1961(3), § 1962(a), and § 1964(c), as set forth below.

82. Each enterprise was engaged in interstate commerce during the relevant times, and the activities of each enterprise affected interstate commerce during those times. Defendants provided medical services, and group health insurance for medical services, to persons who were residents of states other than Nevada. In furtherance of their business activities, Defendants contracted with and purchased from vendors located in states other than Nevada equipment and supplies that were delivered to Defendants' offices in Nevada from those other states by means of interstate transportation. In furtherance of their business activities, Defendants used the United States mails and interstate telephone and wire communications.

1. Humana as RICO "Enterprise" but not as RICO "Person"

83. Humana was an "enterprise" within the meaning of 18 U.S.C. § 1961(4), § 1962(a), and § 1962(c).

84. Defendant Humana Insurance, when not acting as the enterprise, was a "person" within the meaning of 18 U.S.C. § 1961(3), § 1962(a), and § 1964(c).

2. Humana Insurance as RICO "Enterprise" but not as RICO "Person"

85. Humana Insurance was an "enterprise" within the meaning of 18 U.S.C. § 1961(4), § 1962(a), and § 1962(c).

86. Defendant Humana, when not acting as the enterprise, was a "person" within the meaning of 18 U.S.C. § 1961(3), § 1962(a), and § 1964(c).

3. The "Humana Group" as RICO "Enterprise"

87. Humana, Humana Insurance, and the officers and directors of Humana and Humana Insurance were members of an association-in-fact, hereinafter referred to as the "Humana Group," that constituted an "enterprise" within the meaning of 19 U.S.C. § 1961(4), § 1962(a), and § 1962(c).

88. Each of Defendants Humana and Humana Insurance was a "person" within the meaning of 18 U.S.C. § 1961(3), § 1962(a), and § 1964(c).

89. The Humana Group shared common purposes, exhibited distinct divisions of responsibility, existed independently of the pattern of racketeering activity, and continued as an economic unit with the same members at its core during the period from 1984 through 1988.

a. Membership of the Humana Group

90. The Humana Group included, along with Defendants Humana, Humana Insurance, the officers and directors of Humana and Humana Insurance, all companies that prepared and/or disseminated advertising for Humana and/or Humana

Insurance, and all sales brokers who sold policies of group health insurance issued by Humana Insurance.

b. Purposes and Responsibilities of the Humana Group.

91. The general purposes of the Humana Group were to provide medical services by Humana-Sunrise and insurance for medical services by Humana-Sunrise.

92. The specific purposes and responsibilities of Defendant Humana and of the officers and directors of Humana included without limitation providing medical services by Humana-Sunrise.

93. The specific purposes and responsibilities of Defendant Humana Insurance and of the officers and directors of Humana Insurance included without limitation providing insurance for medical services by Humana-Sunrise.

94. The specific purposes and responsibilities of companies that prepared and/or disseminated advertising for Defendant Humana included without limitation promoting the sale of medical services by Humana-Sunrise.

95. The specific purposes and responsibilities of companies that prepared and/or disseminated advertising for Defendant Humana Insurance and of sales brokers included without limitation promoting the sale of insurance for medical services by Humana-Sunrise.

c. Bases for the Humana Group

96. The bases for the association between and among Defendant Humana and the officers and directors of Humana included without limitation the articles of incorporation and bylaws of the firm.

97. The bases for the association between and among Defendant Humana Insurance and the officers and directors

of Humana Insurance included without limitation the articles of incorporation and bylaws of the firm.

98. The bases for the association between Defendants Humana and Humana Insurance included without limitation the contractual preferred-provider agreements they entered into with each other.

99. The bases for the association between and among Defendant Humana and companies that prepared and/or disseminated advertising for Humana included without limitation contractual agreements that Humana entered into with each of them.

100. The bases for the association between and among Defendant Humana Insurance and companies that prepared and/or disseminated advertising for Humana Insurance included without limitation contractual agreements that Humana Insurance entered into with each of them.

101. The bases for the association between and among Defendant Humana Insurance and sales brokers included without limitation contractual agreements that Humana Insurance entered into with each of them.

d. Time Period of the Humana Group

102. The Humana Group was intended to continue for an indefinite period of time. It has in fact continued from 1984 to the date of filing of this Third Amended Complaint.

e. Culpability of the Humana Group

103. The only members of the Humana Group that were aware of all or a portion of the scheme to defraud and to obtain money by means of false pretenses were Humana, Humana Insurance, and the officers and directors of Humana and Humana Insurance.

D. Violations of 18 U.S.C.§ 1962(c)

104. Each Defendant, other than when it was the enterprise, was associated with one of the alternative enterprises and conducted or participated in, directly or indirectly, the conduct of the affairs of that enterprise through a pattern of racketeering activity within the meaning of 18 U.S.C. § 1961(1)(B), § 1961(5), and § 1962(c), viz.:

a. Multiple instances of violations of 18 U.S.C. § 1341;

b. Multiple instances of violations of 18 U.S.C. § 1343;

c. Multiple instances of violations of 18 U.S.C. § 1503.

105. Each Defendant, other than when it was the enterprise, aided and abetted each other Defendant, and persons not presently known to Plaintiffs, in committing the aforementioned violations of 18 U.S.C. 1962(c), all in violation of 18 U.S.C. § 2.

106. Plaintiffs were injured by Defendants' overt acts that violated 18 U.S.C. §2, § 1341, § 1343, and § 1503 during and in furtherance of Defendants' scheme to defraud, to obtain money by false pretenses, and/or to influence, obstruct, and impede the due administration of justice. Defendants' violations of 18 U.S.C. § 1341, § 1343, and § 1503 were additionally predicate acts for purposes of 18 U.S.C. § 1962(c).

E. Violations of 18 U.S.C. 1962(d) conspiracy to violate 18 U.S.C. § 1962(a)

107. Each Defendant, other than when it was the enterprise, conspired with each of the other Defendants, in violation of 18 U.S.C. § 1962(d), to violate 18 U.S.C. § 1962(a) by using or investing, directly or indirectly, in the acquisition of any interest, income, or the establishment or operation of one of the alternative enterprises, part of income

derived, directly or indirectly, from a pattern of racketeering activity viz.:

a. Multiple instances of violations of 18 U.S.C. § 1341;

b. Multiple instances of violations of 18 U.S.C. § 1343;

c. Multiple instances of violations of 18 U.S.C. § 1503.

108. Plaintiffs were injured by Defendants' overt acts that violated 18 U.S.C. §2, § 1341, § 1343, and § 1503 during and in furtherance of Defendants' scheme to defraud, to obtain money by false pretenses, and/or to influence, obstruct, and impede the due administration of justice. Defendants' violations of 18 U.S.C. § 1341, § 1343, and § 1503 were additionally predicate acts for purposes of 18 U.S.C. § 1962(a).

F. Violations of 18 U.S.C. § 1962(d) conspiracy to violate 18 U.S.C. § 1962(c)

1. Conduct or participation in the affairs of the enterprise

109. Each Defendant, other than when it was the enterprise, conspired with each of the other Defendants, in violation of 18 U.S.C. § 1962(d), to violate 18 U.S.C. § 1962(c) by conducting or participating, directly or indirectly, in the conduct of the affairs of one of the alternative enterprises through a pattern of racketeering activity within the meaning of 18 U.S.C. § 1961(1)(B), § 1961(5), and § 1962(c), viz.:

a. Multiple instances of violations of 18 U.S.C. § 1341;

b. Multiple instances of violations of 18 U.S.C. § 1343;

c. Multiple instances of violations of 18 U.S.C. § 1503.

110. Plaintiffs were injured by Defendants' overt acts that violated 18 U.S.C. §2, § 1341, § 1343, and § 1503 during and in furtherance of Defendants' scheme to defraud, to obtain money by false pretenses, and/or to influence, ob-

struct, and impede the due administration of justice. Defendants' violations of 18 U.S.C. § 1341, § 1343, and § 1503 were additionally predicate acts for purposes of 18 U.S.C. § 1962(c).

2. Conduct or participation in a pattern of racketeering activity

111. Each Defendant, other than when it was the enterprise, conspired with each of the other Defendants, in violation of 18 U.S.C. § 1962(d), to violate 18 U.S.C. § 1962(c) by conducting or participating, directly or indirectly, through the conduct of the affairs of one of the alternative enterprises, in a pattern of racketeering activity within the meaning of 18 U.S.C. § 1961(1)(B), § 1961(5), and § 1962(c), viz.:

a. Multiple instances of violations of 18 U.S.C. § 1341;

b. Multiple instances of violations of 18 U.S.C. § 1343;

c. Multiple instances of violations of 18 U.S.C. § 1503.

112. Plaintiffs were injured by Defendants' overt acts that violated 18 U.S.C. §2, § 1341, § 1343, and § 1503 during and in furtherance of Defendants' scheme to defraud, to obtain money by false pretenses, and/or to influence, obstruct, and impede the due administration of justice. Defendants' violations of 18 U.S.C. § 1341, § 1343, and § 1503 were additionally predicate acts for purposes of 18 U.S.C. § 1962(c).

G. Requested Relief

113. By reason of the violations of 18 U.S.C. § 2 and § 1962(c) and (d) committed by Defendants, it is estimated that the actual damages of the RICO class are in excess of $181,034,570.00, the principal of which is subject to trebling.

114. It has become necessary for Plaintiffs to retain the law firms of Jones, Jones, Close & Brown, Chartered; Waite, Schneider, Bayless & Chesley Co., L.P.A.; Cummings, Cummings & Dudenhefer; and Gauthier & Murphy to prosecute this action, and Plaintiffs are entitled to recover reasonable attorneys' fees therefor.

VII

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray for judgment against Defendants, jointly and/or severally, where applicable in each claim for relief as follows:

1. An amount in excess of $84,520,143.00 based on the ERISA violations by Humana Insurance on the First Claim for Relief.

2. Imposition of a constructive trust in the amount of all monies received as a result of the scheme, with Plaintiffs to be named as the beneficiaries of the trust on the First Claim for Relief.

3. Declaratory judgment and permanent injunction establishing the rights and duties between the parties and for judgment requiring Humana Insurance and William Larry Cash to cease and desist from the wrongful conduct described in the First Claim for Relief.

4. General, special, and compensatory damages in an amount in excess of $181,034,570.00 on the Second Claim for Relief, which damages are subject to trebling (excluding interest) for a total amount in excess of $421,426,569.00.

5. Declaratory judgment and permanent injunction requiring Defendants to cease and desist the wrongful conduct described in the Second Claim for Relief.

6. General, special, and compensating damages in an amount in excess of $181,034,570.00 on the Third Claim

for Relief, which damages are subject to trebling (excluding interest) for a total amount in excess of $421,426,569.00.

7. General, special, and compensating damages in an amount in excess of $181,034,570.00 on the Fourth Claim for Relief, which damages are subject to trebling (excluding interest) for a total amount in excess of $421,426,569.00. Costs of suit and fees incurred herein.

8. Any further and additional relief that this Court may deem just and equitable.

DATED this 31st day of October, 1991.

JONES, JONES, CLOSE
& BROWN, CHARTERED

By_____
J. RANDALL JONES, ESQ.
WILL KEMP, ESQ.
300 South Fourth Street
Las Vegas, Nevada 89101

WAITE, SCHNEIDER, BAYLESS
& CHESLEY CO., L.P.A.

By_____
STANLEY M. CHESLEY, ESQ.
1515 Central Trust Tower
Fourth and Vine Streets
Cincinnati, Ohio 45202

CUMMINGS, CUMMINGS & DUDENHEFER

By_____
JOHN L. CUMMINGS III, ESQ.
416 Gravier Street
New Orleans, LA 70130

GAUTHIER & MURPHY

By_____
WENDELL GAUTHIER, ESQ.
3500 North Hullen Street
Metairie, LA 70002

ATTORNEY FOR PLAINTIFFS

Plaintiffs demand a trial by jury on all issues so triable.

JONES, JONES, CLOSE
& BROWN, CHARTERED

By_____
J. RANDALL JONES, ESQ.
WILL KEMP, ESQ.
300 South Fourth Street
Suite 700
Las Vegas, Nevada 89101

Appendix A

Use of the United States Mails During and in Furtherance of the Scheme to Defraud

	Description	Date	From	To
1.	Statement of charges by Humana-Sunrise and amounts paid by Humana Insurance [EOB]	2/7/89	H-Insurance	Andrews
2.	Premium invoice for 8/1/85 - 8/31/85	not shown	Humana, Inc.	Best Glass
3.	Premium invoice for 7/1/86 - 7/31/86	not shown	Humana, Inc.	Best Glass
4.	Premium invoice for 7/1/87 - 7/31/87	not shown	Humana, Inc.	Best Glass
5.	Premium invoice for 7/1/88 - 7/31/88	not shown	Humana, Inc.	Best Glass
6.	Letter soliciting policy renewal and quoting premiums	4/29/88	H-Insurance	Best Glass
7.	Cover letter for Humana Insurance brochure setting forth benefits of policy	not shown	H-Insurance	Bratton
8.	Humana Insurance enrollment form	9/10/87	Bratton	H-Insurance
9.	Statement of charges by Humana-Sunrise and amounts paid by insured	1/22/88	H-Sunrise	Staves
10.	Patient account statement	3/21/88	H-Sunrise	Bratton
11.	Patient account statement	4/17/88	H-Sunrise	Bratton
12.	Patient account statement	5/20/88	H-Sunrise	Bratton
13.	Request for payment of charges by Humana-Sunrise	5/28/88	H-Sunrise	Bratton
14.	Patient account statement	6/11/88	H-Sunrise	Bratton

15.	Request for payment of charges by Humana-Sunrise	7/2/88	H-Sunrise	Bratton
16.	Patient account statement	11/12/88	H-Sunrise	Bratton
17.	Request for payment of charges by Humana-Sunrise	12/3/88	H-Sunrise	Bratton
18.	Statement of charges by Humana-Sunrise and amounts paid by Humana Insurance [EOB]	1/31/89	H-Insurance	Bratton
19.	Statement of charges by Humana-Sunrise and amounts paid by Humana Insurance [EOB]	6/8/89	H-Insurance	Bratton
20.	Statement of charges by Humana-Sunrise and amounts paid by Humana Insurance [EOB]	6/23/89	H-Insurance	Bratton
21.	Patient account statement	6/26/89	H-Sunrise	Bratton
22.	Detailed statement of charges by Humana-Sunrise	9/22/86	H-Sunrise	Buehler
23.	Detailed statement of charges by Humana-Sunrise	10/20/88	H-Sunrise	Buehler
24.	Patient account statement	10/3/89	H-Sunrise	Buehler
25.	Detailed statement of charges by Humana-Sunrise	10/21/87	H-Sunrise	Cade
26.	Detailed statement of charges by Humana-Sunrise	9/18/86	H-Sunrise	Forsyth
27.	Patient account statement	10/25/86	H-Sunrise	Forsyth
28.	Statement of charges by Humana-Sunrise and amounts paid by insured	10/27/86	H-Sunrise	Forsyth
29.	Patient account statement	11/9/86	H-Sunrise	Forsyth

30.	Statement of charges by Humana-Sunrise and amounts paid by insured	12/24/86	H-Sunrise	Forsyth
31.	Detailed statement of charges by Humana-Sunrise	10/20/88	H-Sunrise	Staves
32.	Patient account statement	11/16/88	H-Sunrise	Staves
33.	Patient account statement	12/30/88	H-Sunrise	Staves
34.	Detailed statement of charges by Humana-Sunrise	1/9/89	H-Sunrise	Staves
35.	Statement of charges by Humana-Sunrise and amounts paid by insured	1/9/89	H-Sunrise	Staves
36.	Patient account statement	1/9/89	H-Sunrise	Staves
37.	Patient account statement	1/10/89	H-Sunrise	Staves
38.	Statement of charges by Humana-Sunrise and amounts paid by Humana Insurance [EOB]	1/11/89	H-Insurance	Staves
39.	Patient account statement	1/12/89	H-Sunrise	Staves
40.	Statement of charges by Humana-Sunrise and amounts paid by Humana Insurance [EOB]	1/19/89	H-Insurance	Staves
41.	Patient account statement	1/20/89	H-Sunrise	Staves
42.	Request for payment of charges by Humana-Sunrise	1/29/89	H-Sunrise	Staves
43.	Statement of charges by Humana-Sunrise and amounts paid by Humana Insurance [EOB]	10/8/89	H-Insurance	Staves
44.	Patient account statement	10/10/89	H-Sunrise	Staves

Appendix B

Interstate Telephone and Wire Communications During and in Furtherance of the Scheme to Defraud

	Description	Date	From	To
1.	Approximately 14,000,000 interstate telephone communications involving business activities of Defendants [*see* Exhibit 1]	1984-1988	Defendants, Plaintiffs, and others	Defendants Plaintiffs, and others
2.	Indeterminate number of interstate telephone communications involving claims payments by Defendants [*see* Exhibit 2]	1987-1988	Defendants, Plaintiffs, and others	Defendants, Plaintiffs, and others
3.	Interstate telephone communications involving charges by Humana-Sunrise and co-payments by Humana Insurance [*see* Exhibit 3]	1986-1987	Rudolph K. Whalen [Arizona]	H-Sunrise [Nevada], H-Insurance [Nevada], Mutual Administrators [Nevada]
4.	Interstate telephone communication involving business activities of Defendants [*see* Exhibit 4]	5/2/89	John Andris of Humana, Inc. [Kentucky]	Herschell Dunham of Nevada Division of Insurance [Nevada]
5.	Interstate wire transfer of $1,501,335.63 [*see* Exhibit 5]	3/2/84	Humana, Inc. [Kentucky]	H-Insurance [Nevada]
6.	Interstate wire transfer of $ [illegible] [*see* Exhibit 6]	6/17/87	H-Insurance [Nevada]	First National Bank [Boston]

J. RANDALL JONES, ESQ.
WILL KEMP, ESQ.
JONES, JONES, CLOSE
& BROWN, CHARTERED
700 Valley Bank Plaza
300 South Fourth Street
Las Vegas, NV 89101-6026
Telephone: (702) 385-4202

STANLEY M. CHESLEY, ESQ.
WAITE, SCHNEIDER, BAYLESS &
CHESLEY CO., L.P.A.
1515 Central Trust Tower
Fourth and Vine Streets
Cincinnati, OH 45202

JOHN L. CUMMINGS III, ESQ.
CUMMINGS, CUMMINGS & DUDENHEFER
416 Gravier Street
New Orleans, LA 70130

WENDELL GAUTHIER, ESQ.
GAUTHIER & MURPHY
3500 North Hullen Street
Metairie, LA 70002

ATTORNEYS FOR PLAINTIFFS

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO. CV-S-89-249-PMP (L.R.L.)

MARY FORSYTH; MARRIETTA CADE; WILLIE ANDREWS; MARY LOU BUEHLER; HELEN STAVES; RANDOLPH BRATTON; and SEARLE AUTO GLASS, INC., doing business as BEST GLASS COMPANY,

Plaintiffs,

vs.

HUMANA, INC., a Delaware corporation; HUMANA HEALTH INSURANCE OF NEVADA, INC., a Nevada corporation; and DOES I through X, inclusive,

Defendants.

MOTION FOR LEAVE TO FILE THIRD AMENDED COMPLAINT AND JURY DEMAND

Plaintiffs, by and through their counsel of record, Jones, Jones, Close & Brown, Chartered, hereby file this Motion for Leave to File Third Amended Complaint and Jury Demand. This Motion is based on Fed. R. Civ. P. 15, the pleadings and papers on file with the Court, and the points and authorities set forth herein.

POINTS AND AUTHORITIES

I

STATEMENT OF THE CASE

On March 29, 1989, Plaintiffs filed their initial Complaint in this matter. On April 28, 1989, Defendants filed a Motion to Dismiss that Complaint. On September 27, 1989, this Court entered an Order effectively denying Defendants' Motion to Dismiss. On October 27, 1989, Plaintiffs filed an Amended Complaint in response to the rulings in that Order. On January 18, 1990, Defendants filed a Second Motion to Dismiss. On July 9, 1991, this Court entered an Order effectively denying that Second Motion to Dismiss. In that Order the Court granted Plaintiffs leave to file a Second Amended Complaint, and on August 12, 1991, Plaintiffs filed their Second Amended Complaint. On September 4, 1991, Defendants filed their first Answer.

II

STATEMENT OF THE LAW

Fed. R. Civ. P. 15(a) allows a party to apply for leave to amend a pleading, and provides that "leave shall be freely given when justice so requires." One authority has observed that "[s]ubdivision (a) encourages the court to look favorably on requests to amend . . . . This proposition has been reinforced by innumerable judicial pronouncements by the federal appellate and district courts alike." 6 Charles A. Wright, Arthur R. Miller, & Mary K. Kane, *Federal Practice and Procedure* § 1483 (1990). Most significantly, the United States Supreme Court declared in *Foman v. Davis*, 371 U.S. 178 (1962), that

> If the underlying facts or circumstances relied upon by a plaintiff may be a proper subject of relief, he ought to be afforded an opportunity to test his claim on the merits. In the absence of any apparent or declared reason . . . the leave sought should, as the rules require, be "freely given."

Id., 371 U.S. at 182. *See also, e.g., United States v. Webb*, 655 F.2d 977 (9th Cir. 1981); *Hurn v. Retirement Fund Trust, Etc.*, 648 F.2d 1252 (9th Cir. 1981). In *Howey v. United States*, 481 F.2d 1187 (9th Cir. 1973), the Ninth Circuit reversed a denial of leave to amend, even five years after the initial complaint was filed, in the absence of prejudice to the defendant.

Plaintiffs' proposed Third Amended Complaint is additionally a supplemental pleading pursuant to Fed. R. Civ. P. 15(d). One of the reasons for the adoption of paragraph (d) is that otherwise a plaintiff might be forced into "commencing a new action even though events occurring after the commencement of the original action have made clear the right to relief." Fed. R. Civ. P. 15 advisory committee notes (1963). That is precisely the situation here.

III

ARGUMENT

1. Allegations regarding Defendants' RICO conspiracy.

Plaintiffs file this Third Amended Complaint to allege violations of 18 U.S.C. § 1962(d), i.e., a conspiracy to violate 18 U.S.C. §§ 1962(a) and (c) of the federal RICO statutes. In its Order of July 9, 1991, this court dismissed a portion of Plaintiffs' RICO claims pursuant to 18 U.S.C. § 1962(a). The Court adopted the rule of some federal circuits that Plaintiffs were required to establish an injury by reason of the use or investment of racketeering income. The Court concluded that Plaintiffs "have not alleged injury resulting from investment of racketeering income, and could not do so even if they had the chance to amend." Order at 38.

On August 16, 1990, after Plaintiffs had filed both their initial Complaint and their first Amended Complaint, the Ninth Circuit issued an opinion in *Reddy v. Litton Indus., Inc.*, 912 F.2d 291 (9th Cir. 1990), *cert. denied*, 60 U.S.L.W. 3057 (October 15, 1991) that addressed the requirements for establishing a *conspiracy* to violate 18 U.S.C. 1962(a), pursuant to the conspiracy portion of the RICO statutes, 18 U.S.C. § 1962(d). The Court held: "[A] plaintiff must have been injured by overt acts that are themselves statutorily defined acts of racketeering in order to have standing under § 1962(d)," *id.* at 295—i.e., by the predicate act itself, and not necessarily by the use or investment of racketeering income. In other words, the injury requirement for alleging a *conspiracy* to violate 18 U.S.C. § 1962(a), (b), or (c) leapfrogs those intermediate provisions and concentrates on the predicate act itself. Accordingly Plaintiffs now wish to amend their Complaint to allege that Defendants conspired to violate 18 U.S.C. § 1962(a) and (c).

2. Allegations regarding Wendell Cherry and William Larry Cash.

The proposed Third Amended Complaint additionally joins two culpable parties to this litigation: the estate of Wendell Cherry and its administrator, and William Larry Cash. Plaintiffs' grounds for joining those Defendants are set forth at length in the attached Third Amended Complaint 5-6 and *passim.*

3. Absence of prejudice to Defendants.

Granting Plaintiffs leave to file this Third Amended Complaint will not unduly prejudice Defendants, for the following reasons:

—Plaintiffs allege no new operative facts. The same transactions, occurrences, relationships, and injuries that animated Plaintiffs' earlier complaints remain at the core of this Third Amended Complaint. Hence this litigation will not assume any essential new character by reason of the allegations set forth in this proposed Third Amended Complaint.

—The additional co-Defendants were knowing, willful, and active participants in the scheme to defraud. Hence they were aware of the transactions, occurrences, relationships, and injuries alleged in this litigation even long before Plaintiffs filed their initial Complaint. Moreover, those additional co-Defendants were aware of this litigation itself from the outset thereof and of Plaintiffs' allegations therein.

—The parties to this litigation have engaged in relatively few essential depositions. By far the larger portion of those essential depositions remain to be scheduled. Plaintiffs alone presently contemplate scheduling more than twenty-five depositions hereafter.

—More than three months remain in this litigation for discovery efforts and motions. That is entirely adequate for Defendants to pursue all necessary discovery activities.

III

CONCLUSION

For all of the foregoing reasons, Plaintiffs respectfully request leave to file a Third Amended Complaint and Jury Demand in conformance with Exhibit 1.

DATED this 31st day of October, 1991.

Respectfully submitted,

JONES, JONES, CLOSE
& BROWN, CHARTERED

By /s/ Will Kemp
J. RANDALL JONES, ESQ.
JOHN W. FIELD, ESQ.
300 Valley Bank Plaza
300 South Fourth Street
Las Vegas, Nevada 89101

ATTORNEYS FOR PLAINTIFFS

RECEIPT OF COPY

RECEIPT of a true and correct copy of the attached PLAINTIFFS' MOTION FOR LEAVE TO FILE THIRD AMENDED COMPLAINT AND JURY DEMAND is hereby acknowledged this ____ day of October, 1991.

LIONEL SAWYER & COLLINS

By_____
LOUIS E. GARFINKEL, ESQ.
1600 Valley Bank Plaza
300 South Fourth Street
Las Vegas, Nevada 89101

CERTIFICATE OF MAILING

I hereby certify that on the 31st day of October, 1991, the foregoing PLAINTIFFS' MOTION FOR LEAVE TO FILE THIRD AMENDED COMPLAINT AND JURY DEMAND was served on the following by mailing a copy thereof, first class mail, postage prepaid, to:

Mark J. Biros, Esq.
CASSON, HARKINS & LAPALLO
1233 20th Street, N.W., #800
Washington, D.C. 20036

/s/ Jill S. Fletcher
An employee of JONES, JONES, CLOSE & BROWN, CHARTERED

J. RANDALL JONES, ESQ.
JONES, JONES, CLOSE
& BROWN, CHARTERED
700 Valley Bank Plaza
300 South Fourth Street
Las Vegas, NV 89101-6026
Telephone: (702) 385-4202

ATTORNEYS FOR PLAINTIFFS

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO. CV-S-89-249 PMP (L.R.L.)

MARY FORSYTH; MARRIETTA CADE; WILLIE ANDREWS; MARY LOU BUEHLER; HELEN STAVES; RANDOLPH BRATTON ; and SEARLE AUTO GLASS, INC., doing business as BEST GLASS COMPANY,

Plaintiffs,

vs.

HUMANA, INC., a Delaware corporation; HUMANA HEALTH INSURANCE OF NEVADA, a Nevada corporation; and DOE CORPORATIONS I through V, inclusive,

Defendants.

ORDER

The Court having considered the arguments of counsel, and good cause appearing, it is hereby

ORDERED, that Plaintiffs may file their Third Amended Complaint.

DATED this ____ day of _____, 1991.

_____
UNITED STATES DISTRICT COURT JUDGE

Submitted By:

JONES, JONES, CLOSE
& BROWN, CHARTERED

By /s/ Will Kemp
J. RANDALL JONES, ESQ.
JOHN W. FIELD, ESQ.
700 Valley Bank Plaza
300 South Fourth Street
Las Vegas, Nevada 89101-6026

ATTORNEYS FOR PLAINTIFFS

Mark J. Biros
Thomas H. Brock
CASSON & HARKINS
1233 20th Street, N.W.
Suite 800
Washington, D.C. 20036
Telephone: (202) 778-1100

Dennis L. Kennedy
Louis E. Garfinkel
LIONEL SAWYER & COLLINS
300 So. Fourth Street
Suite 1700
Las Vegas, Nevada 89101
Telephone: (702) 383-8888

Attorneys for Defendants Humana Inc.
and Humana Health Insurance of Nevada, Inc.

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE No. CV-S-89-249-PMP (LRL)

MARY FORSYTH, *et al.*,

Plaintiffs,

v.

HUMANA, INC., *et al.*,

Defendants.

DEFENDANTS' MEMORANDUM OF POINTS AND AUTHORITIES IN OPPOSITION TO PLAINTIFFS' MOTION FOR LEAVE TO FILE THIRD AMENDED COMPLAINT

I. INTRODUCTION

More than two and a half years after commencing this litigation, Plaintiffs have moved this Court for leave to file a

Third Amended Complaint. The Third Amended Complaint seeks to add new parties and new claims, and to revise the old claims against Defendants. Unfortunately, these amendments would alter the course and the pace of this action significantly.

Although the standards for leave to amend are liberal, leave should not be granted in every situation. Leave should be denied when it will prejudice the defendants or unduly delay the action without justification. Here, Defendants would be prejudiced because the Third Amended Complaint would effectively nullify Defendants' efforts over the past two and a half years to narrow and refine the scope of Plaintiffs' pleadings. In addition, the Third Amended Complaint would substantially delay this litigation by generating a renewed motion to dismiss and a renewed discovery process.

Furthermore, Plaintiffs cannot justify another amendment to their pleadings because the matters contained in the Third Amended Complaint generally could have been asserted in Plaintiffs' earlier pleadings and now will only cause further delay. It is time to move forward with this case to an adjudication on the merits. Defendants are eager for vindication in this litigation, but Plaintiffs' Third Amended Complaint will only delay the disposition of Plaintiffs' claims. Accordingly, Plaintiffs' motion for leave to amend should be denied.

II. STATEMENT OF FACTS

On March 29, 1989, Plaintiffs filed their original complaint with this Court, alleging claims under the Employee Retirement Income Security Act ("ERISA"), the Sherman Antitrust Act and various provisions of state law. On September 27, 1989, the Court dismissed Plaintiffs' state law claims and directed them to file an Amended Complaint re-asserting the ERISA and antitrust counts. Plaintiffs filed the Amended Complaint on October 27, 1989, alleging claims under ERISA and section 2 of the Sherman Antitrust

Act, and adding claims under the Racketeer Influenced and Corrupt Organizations Act ("RICO"). On July 9, 1991, the Court dismissed a portion of Plaintiffs' claims under RICO, and ordered Plaintiffs to file a Second Amended Complaint. The Second Amended Complaint was filed on August 12, 1991, which Defendants answered on September 4, 1991.

In the belief that Plaintiffs' allegations had finally been framed in the Second Amended Complaint, Defendants propounded extensive written discovery directed at exploring Plaintiffs' contentions in the Second Amended Complaint. On October 17, 1991, each Plaintiff's deposition was noticed in order to probe the bases of the allegations in the Second Amended Complaint. On September 11, 1991, all counsel met to confer on the discovery issues raised in the case. As a result of this meeting, the Court ordered the parties to complete all discovery by January 31, 1992. This order was based on the parties' September 18, 1991 status report to the Court which was prepared by both sides. At no point before or during the discovery conference did Plaintiffs indicate that they expected to amend their complaint a third time. Nonetheless, Plaintiffs now seek leave to file yet another amended complaint, containing two major changes.

First, the Third Amended Complaint attempts to join as defendants the Estate of Wendell Cherry ("Cherry"), the late president, chief operating officer, and director of Defendant Humana Inc.; and William Larry Cash ("Cash"), an officer and director of Defendant Humana Insurance. Plaintiffs' allegations do nothing more than attribute the activities of the existing Defendants to Cherry and Cash as individuals simply by virtue of their positions at Humana and Humana Insurance. Furthermore, Plaintiffs have not alleged that either of these parties committed acts unknown to the Plaintiffs on March 29, 1989, when they filed their original complaint.

Second, the Third Amended Complaint alleges additional acts by Defendants in connection with the ERISA claims, and changes their antitrust claims. Furthermore, Plaintiffs alter their allegations regarding the identity of the RICO "person" and "enterprise;" add new RICO conspiracy claims; and finally, introduce a new cause of action for violation of the Nevada racketeering laws. However, Plaintiffs introduce no facts to justify such amendments and changes.[1]

In sum, Plaintiffs' Third Amended Complaint attempts to raise legal theories that could have been asserted in earlier pleadings. Permitting Plaintiffs to now modify their claims will sacrifice judicial economy by triggering a new wave of motions and discovery, and will require Defendants to return their defense to square one. This could be costly to the Court and Defendants, and would extend the litigation. Because the Third Amended Complaint will materially prejudice Defendants and unduly prolong this action, Plaintiffs' motion for leave to amend should be denied.

---

[1] Plaintiffs' amended RICO claim does include a new allegation that Defendants have committed an obstruction of justice under 18 U.S.C. § 1503. The allegation is based upon a series of purported discovery misconduct. These matters constitute discovery disputes. Thus, in connection with these same issues, Plaintiffs have filed a motion under Fed. R. Civ. P. 37 seeking discovery sanctions. Elevating these procedural skirmishes to a substantive criminal offense in this complaint seems hardly appropriate. Indeed, Plaintiffs' attempt to bootstrap discovery disputes into an additional cause of action is without precedent. Defendants have been unable to find any caselaw to support this effort. Plaintiffs, unfortunately, provide none either. Additionally, Plaintiffs' actions are anomalous. Plaintiffs specifically asked this Court to file their Rule 37 motion under seal, presumably to avoid impermissible interference with a pending jury trial ongoing in state court. Yet they make no such request with respect to the Third Amended Complaint, containing the same inflammatory allegations.

III. ARGUMENT

A. This Court Has The Discretionary Power To Deny Plaintiffs' Motion For Leave To File Their Third Amended Complaint.

Although Fed. R. Civ. P. 15(a) states that leave to amend a pleading "shall be freely given when justice so requires," the mere request for leave to amend does not create an entitlement to relief. Instead, the power to grant or deny leave is within the discretion of the district court. *Foman v. Davis*, 371 U.S. 178, 182 (1962). Under this standard, the district courts have developed several grounds for evaluating a request for leave to amend. First, "the district court's discretion to deny leave to amend is particularly broad where the court has already given the plaintiff an opportunity to amend his complaint." *See Fidelity Financial Corp. v. Federal Home Loan Bank of San Francisco*, 792 F.2d 1432, 1438 (9th Cir. 1986), *cert. denied*, 479 U.S. 1064 (1987).

Second, a court may properly deny leave to amend "if permitting an amendment would prejudice the opposing party, produce an undue delay in the litigation, or result in futility for lack of merit." *Jackson v. Bank of Hawaii*, 902 F.2d 1385, 1387 (9th Cir. 1990). *See generally Ascon Properties, Inc. v. Mobile Oil Co.*, 866 F.2d 1149 (9th Cir. 1989) (court denied leave for a third time because defendant would suffer prejudice); *McGlinchy v. Shell Chemical Co.*, 845 F.2d 802 (9th Cir. 1988) (leave denied, in part, because appellants should have been aware of their claim when they filed their original complaint, thereby causing undue delay); *Allen v. City of Beverly Hills*, 911 F.2d 367 (9th Cir. 1990) (allegations raised could not support a cause of action if added to the complaint).

Third, the trial court may deny leave when a party presents no new facts in the proposed pleading, but only seeks to introduce new theories without a satisfactory explanation for the failure to develop fully those contentions

originally. *Allen*, 911 F.2d at 374; *McGlinchy*, 845 F.2d at 809.

Using these three standards, this Court should reject Plaintiffs' attempt to file their *Third* Amended Complaint. Plaintiffs' primary justification for their Third Amended Complaint is the decision of the Ninth Circuit in *Reddy v. Litton Industries, Inc.*, 912 F.2d 291 (9th Cir. 1990), *cert. denied*, 60 U.S.L.W. 3288 (1991). In this decision, according to Plaintiffs, the Ninth Circuit repudiated the "investment only" rule with respect to RICO conspiracy claims.

Even though Defendants believe Plaintiffs' interpretation of *Reddy* is erroneous,[2] there are other reasons why the *Reddy* decision does not justify Plaintiffs' request for leave to amend. First, *Reddy* was issued by the Ninth Circuit in August, 1990, more than one year ago and is not the very recent opinion Plaintiffs imply it is. Plaintiffs have had nearly sixteen months to advise the Court of the *Reddy* decision, to file an amended complaint with the Court, and to seek leave to amend their complaint to allege a RICO conspiracy in violation of § 1962(d). In fact, the *Reddy* decision was one year old when Plaintiffs filed their Second Amended Complaint on August 12, 1991, and they could easily have included a conspiracy claim under § 1962(d) in that complaint. Second, even if Plaintiffs can explain their failure to invoke *Reddy* earlier, it is a limited RICO ruling

---

[2] The *Reddy* court specifically declined to abrogate the investment only rule. *Reddy*, 912 F.2d at 296. No case decided subsequent to *Reddy* supports Plaintiffs' interpretation. *See Saul v. United States*, 928 F.2d 829, 843 (9th Cir. 1991); *Price v. Hawaii*, 921 F.2d 950, 958 (9th Cir. 1990); *U.S. Concord, Inc. v. Harris Graphics Corp.*, 757 F. Supp. 1053, 1060-61 (N.D. Cal. 1991).

that does not justify Plaintiffs' attempt to introduce a wide variety of amendments in addition to a RICO conspiracy claim.[3]

Therefore, Plaintiffs' proposal to amend their complaint based upon *Reddy* should be viewed with skepticism. A detailed analysis of the individual amendments in the Third Amended Complaint demonstrates that this skepticism should result in a denial of Plaintiffs' request for leave to amend.

B. Plaintiffs Should Be Denied Leave To Join The Estate Of Wendell Cherry And William Larry Cash As Defendants.

On a purely equitable level, Plaintiffs never identify any reason, either in their motion or the proposed complaint itself, why either Cherry or Cash should, or must, be brought into this litigation at this late date. The corporate Defendants have not asserted that either Cherry or Cash acted outside the scope of their duties in an effort to preclude corporate liability for any action of the two individuals. Plaintiffs themselves have not alleged any action by the two individuals for which the corporate Defendants would not be liable.

---

[3] In addition, the other cases cited by Plaintiffs in support of leave to amend are inapposite because they involved situations in which the only basis for objection to the amendment was a delay of the litigation. *See Foman v. Davis*, 371 U.S. 178, 182 (1962); *United States v. Webb*, 655 F.2d 977, 980 (9th Cir. 1981); *Hurn v. Retirement Fund Trust, Etc.*, 648 F.2d 1252, 1254 (9th Cir. 1981); *Howey v. United States*, 481 F.2d 1187, 1190-91 (9th Cir. 1973). Here, by contrast, Defendants have demonstrated that apart from undue delay, leave to amend is unjustified because Plaintiffs have failed to allege the development of new facts and Plaintiffs' amendment would prejudice Defendants significantly. *See Jackson*, 902 F.2d at 1387; *Ascon*, 866 F.2d at 1160-61.

Furthermore, the participation of Cherry and Cash as Defendants is not necessary to permit Plaintiffs to pursue their theories of liability. There is no legal necessity to name each of the alleged conspirators as defendants in order to recover from any other participant in the purported conspiracy.

One can only speculate as to why, two and a half years after this lawsuit was filed, Plaintiffs would now elect to label the recently-deceased president of one corporate Defendant and the vice president of the other as "racketeers."[4] This Court may exercise its discretion to avoid this unnecessary consequence of the requested amendment, with absolutely no prejudice to Plaintiffs' right to prosecute their claims.

Additionally, if the proposed amendments are evaluated on a purely legal basis, leave to amend as to Cherry and Cash should be denied for the reasons set forth below.

1. Prejudice to Defendants.

Leave to amend may be denied when it will prejudice the defendants. *See Jackson*, 902 F.2d at 1387; *McGlinchy*, 845 F.2d at 809; *Ascon*, 866 F.2d at 1160-61. In the instant case, Cherry and Cash will clearly be prejudiced if they are joined as parties. These individuals were never placed on notice of any potential individual liability when Plaintiffs

[4] Plaintiffs, in their Ninth Request for Production of Documents directed to Defendants, sought material from the Estate of Wendell Cherry. One can only hope that the decision to name Cherry's Estate is not an improper attempt to facilitate discovery or an unseemly prelude to a litigation strategy designed to exert emotional pressure upon the corporate Defendants through active litigation against the Estate. *See Webb*, 655 F.2d at 980 (bad faith amendment grounds for denying leave to amend). *See also Hurn*, 648 F.2d at 1254; *Howey*, 481 F.2d at 1190-91.

filed their earlier pleadings. It is manifestly unjust for these individuals now to be joined in litigation already two and a half years old; the action has taken a shape over which they had no control.

This is particularly true as to Cherry. Plaintiffs have known of the activities of Cherry at all times during this litigation, and waited until Cherry was deceased to name him as a party. This loss of access to a potentially vital witness is clearly prejudicial. *See Boris v. Moore*, 253 F.2d 523, 524 (7th Cir. 1958).

2. Delay of the Litigation.

Leave to amend also may be denied when it will result in a delay of the litigation. *See Ascon*, 866 F.2d at 1160-16 (leave denied because defendant would suffer prejudice due to substantial litigation costs already incurred and the prospect of additional time, expense and discovery); *Lewis v. Berry*, 109 F.R.D. 42, 43 (W.D. Wash. 1985) (additional claims would necessitate new discovery, additional motions and a postponement of trial which would be extremely prejudicial to parties).

Here, the addition of the individual Defendants will significantly prolong this action. For example, Cherry and Cash likely will move to dismiss the Third Amended Complaint.[5] Moreover, the addition of these individuals

[5] The liability of corporate officers for the activities of the corporation they serve is a real issue that must be examined by the Court. For example, the primary emphasis of Plaintiffs' new RICO theory is that the corporate Defendants, Cherry and Cash conspired to violate sections 1962(a) and 1962(c) of RICO, in violation of section 1962(d). But this attempt to impute liability is not supportable. No Ninth Circuit appellate cases have addressed the issue of whether a properly pled RICO conspiracy under § 1962(d) may consist solely of a corporation, its officers, em-

would expand the scope of the litigation and necessarily increase the time required to complete discovery without in any manner advancing Plaintiffs' theories of liability or facilitating proof of their claims.

3. Absence of New Facts.

A court may deny leave when the movant presents no new facts, only new theories based upon facts previously in

---

ployees or subsidiaries. However, in a RICO case more recent than the *Reddy* case upon which Plaintiffs rely, and one which cites *Reddy*, the District Court in *U.S. Concord, Inc. v. Harris Graphics Corp.*, 757 F. Supp. 1053, 1060-61 (N.D. Cal. 1991), specifically ruled that a corporation may not be held liable under § 1962(d) for a conspiracy involving it, its employees and directors. This ruling follows the majority of District Court decisions which have decided the issue. *Compare Lawaetz v. Bank of Nova Scotia*, 653 F. Supp. 1278, 1287 (D.V.I. 1987); *H.G. Gallimore, Inc. v. Abdula*, 652 F. Supp. 437, 447 n.5 (N.D. Ill. 1987); *Gaudette v. Panos*, 650 F. Supp. 912, 913-14 (D. Mass. 1987), *rev'd on other grounds*, 852 F.2d 30 (1st Cir. 1988); *Satellite Financial Planning Corp. v. First Nat'l Bank of Wilmington*, 633 F. Supp. 386, 405 n.23 (D. Del. 1986); *Medallion TV Enterprises, Inc. v. SelecTV of California, Inc.*, 627 F. Supp. 1290, 1301 n.7 (C.D. Cal. 1986), *aff'd*, 833 F.2d 1360 (9th Cir. 1988), *cert. denied*, 109 S. Ct. 3241 (1989); *McLendon v. Continental Group, Inc.*, 602 F. Supp. 1492, 1510-12 (D. N.J. 1985); *with Pandick, Inc. v. Rooney*, 632 F. Supp. 1430, 1435-36 (N.D. Ill. 1986); *Callan v. State Chemical Mfg. Co., Inc.*, 584 F. Supp. 619, 623 (E.D. Pa. 1984); *Saine v. AIA, Inc.*, 582 F. Supp. 1299, 1307 (D. Colo. 1984). Only one circuit court has held that a conspiracy between a corporation and its employees may be proved, but under circumstances different from those alleged here. *See Ashland Oil, Inc. v. Arnett*, 875 F.2d 1271, 1281 (7th Cir. 1989). No other circuit courts have addressed the issue. Consequently, the attempt to include Cherry and Cash is legally defective. *See Foman*, 371 U.S. at 182 (futility of amendment is factor in denying leave to amend). *See also Webb*, 655 F.2d at 980; *Hurn*, 648 F.2d at 1254; *Howey*, 481 F.2d at 1190-91. More generally, there are a variety of other defenses which can be raised by Cherry and Cash which were not at issue until now.

existence, especially where, as here, there is no explanation why such theories were not developed earlier. *See Allen*, 911 F.2d at 374 (leave denied because movant presented no new facts, only a different legal theory); *Fidelity*, 792 F.2d at 1438 (leave denied because movant was reasserting prior claims under new labels with facts known to movant long before); *Sierra Club v. Union Oil Co. of Cal.*, 813 F.2d 1480, 1493 (9th Cir. 1987) ("where the party seeking the amendment knows or should know of the facts underlying the amendment when the original complaint is filed, the motion to amend may be denied"), *cert. granted, vacated*, 485 U.S. 931 (1988).

Plaintiffs do not allege any new facts in their Third Amended Complaint in their attempt to state a claim against Cherry and Cash. Instead, the Third Amended Complaint realleges the purported misconduct heretofore attributed to the corporate Defendants and merely alleges that the individual Defendants are liable in their official capacities. Such generic allegations against Humana's officers and directors could have been asserted in Plaintiffs' original complaint over two and a half years ago. Plaintiffs offer no explanation or justification as to why Cherry or Cash were not joined in any of their three earlier complaints or why these individuals should be joined at this late date.

Accordingly, the Court should deny Plaintiffs leave to join Cherry and Cash as defendants.

C. Plaintiffs Should Be Denied Leave To Add Additional Claims Against The Original Parties To This Litigation.

Plaintiffs also seek to amend their claims against the existing corporate Defendants. As noted above, this motion is based exclusively on the year-old decision of the Ninth Circuit in *Reddy* which, at best, is relevant only to an amendment of Plaintiffs' new RICO conspiracy claims.

However, without informing the Court in their motion, Plaintiffs have completely rewritten their claims under both ERISA and section 2 of the Sherman Act in their Third Amended Complaint; they have added a claim under Nevada's "little RICO" statute; and they have even revised the RICO claim under 18 U.S.C. § 1962(c), which the Court permitted Plaintiffs to pursue in its July 9, 1991 Order.

This tack is highly questionable because the significance of these proposed changes, especially to the ERISA and antitrust counts, is uncertain. Even after a detailed comparison of the allegations of the pending Second Amended Complaint and the claims set forth in the proposed Third Amended Complaint, it is not clear whether Plaintiffs intend to change the substance of their claims under ERISA and the antitrust laws. Before leave is granted, Plaintiffs should be required to answer these questions. Due to the existing ambiguities in Plaintiffs' proposed claims, however, the corporate Defendants are obliged to oppose the motion for leave to file the Third Amended Complaint.

1. Prejudice to Defendants.

The Court should deny Plaintiffs' leave to file the Third Amended Complaint because the amendment will substantially prejudice the corporate Defendants. *See Jackson*, 902 F.2d at 1387; *McGlinchy*, 845 F.2d at 809; *Ascon*, 866 F.2d at 1161 (leave to amend denied because filing of third complaint would prejudice defendants). A review of the facts demonstrates that prejudice would result if leave is granted.

First, defendants have endeavored over the past two and a half years to narrow and refine the scope of Plaintiffs' pleadings so that Defendants could prepare their defense to cognizable claims. Expending significant resources, Defendants have twice moved to dismiss Plaintiffs' claims for

pleading deficiencies which the Court recognized. However, after Plaintiffs filed their Second Amended Complaint, Defendants believed the issues to be adjudicated in this litigation had finally been framed and a course of discovery was charted. Now Plaintiffs request leave to file an amended pleading that will force Defendants to relitigate additional dispositive motions.

Second, Defendants have already propounded extensive written discovery tailored to ascertain the basis for particular allegations in the Second Amended Complaint. This discovery would be rendered moot by the Third Amended Complaint, forcing Defendants to issue new discovery requests. For these reasons, Defendants will be significantly prejudiced if this Court grants Plaintiffs leave to file the Third Amended Complaint.

Third, the timing of Plaintiffs' motion for leave to amend severely prejudices the corporate Defendants' ability to gather information relevant to Plaintiffs' claims. For the first time in two and a half years, Plaintiffs have suggested that Wendell Cherry was somehow uniquely involved in the alleged RICO conspiracies. Prior to Cherry's death, however, Plaintiffs not only refrained from making any such allegations, they did not even notice Cherry's deposition to determine if such allegations were proper. Plaintiffs' litigation strategy has effectively prevented Defendants from obtaining information regarding the alleged activities giving rise to liability from the best, if not, only source: Mr. Cherry himself.

2. Delay of the Litigation.

This Court also should deny Plaintiffs leave to amend because the filing of the Third Amended Complaint will unduly delay the litigation. *See Ascon*, 866 F.2d at 1161; *Lewis*, 109 F.R.D. at 43.

In a case of this magnitude, there is a need to gain control of the facts and issues within a reasonable time. Thus, the Court has established a discovery cut-off date. The parties have already embarked on a pattern of discovery in an effort to meet the Court's discovery deadline. An amendment to Plaintiffs' complaint at this time would require another motion to dismiss and additional discovery that probably could not be completed within the current discovery period.

Moreover, Plaintiffs' addition of a state RICO claim and federal RICO conspiracy claims to this class action requires a new class certification procedure pursuant to Fed. R. Civ. P. 23(c)(1). *See Zenith Laboratories, Inc. v. Carter-Wallace, Inc.*, 64 F.R.D. 159, 164 (D.N.J. 1974), *aff'd*, 530 F.2d 508 (3d Cir.), *cert. denied*, 429 U.S. 828 (1976). If these new claims were certified for class action treatment, class members would require a new notice of their right to opt out of the litigation. *See* Fed. R. Civ. P. 23(c)(2); *Matarazzo v. Friendly Ice Cream Corp.*, 70 F.R.D. 536, 560 (E.D.N.Y. 1976). The delay caused by this procedure warrants the denial of leave to amend. *See Matarazzo*, 70 F.R.D. at 560 (leave to amend denied because of delay caused by need to deliver new opt-out notice).

In sum, the addition of the claims set forth in the Third Amended Complaint would delay this litigation significantly.

3. Absence of New Facts.

This Court has the discretion to deny leave to amend when the movant attempts to change its theories of liability without alleging the occurrence of any new facts to support such theories. *See Allen*, 911 F.2d at 374.

Plaintiffs seek to expand their ERISA claims by adding alleged instances of misconduct by Defendants. For example, Plaintiffs contend that Defendants submitted a fraudulent master policy to the Insurance Division of Nevada. *See* Third Amended Complaint at ¶¶ 50-51. This is a new theory of recovery based upon facts that could have been asserted in any of Plaintiffs' earlier pleadings. The submission of the master policy to the Insurance Division was known to Plaintiffs when they initiated this suit in March, 1989, and Plaintiffs offer no explanation as to why the introduction of this fact has been delayed until the present time.

These same problems may exist as to the antitrust claim, even though Plaintiffs have developed no new facts to support this effort. Plaintiffs have had three previous opportunities to fine tune their antitrust claim, and without the assertion of recently discovered facts, they should not be permitted to do so again.

With respect to their RICO claim, Plaintiffs propose to modify their definitions of the RICO "persons" and the RICO "enterprise," and to add RICO conspiracy claims. Plaintiffs have also, at this late stage, moved the Court for leave to add a Fourth Claim for Relief alleging violations of Nevada racketeering laws. This state law claim could have been asserted in Plaintiffs' original complaint. These amendments amount only to shifts in Plaintiffs' legal theories. Plaintiffs have offered no explanation as to why these claims for relief were not raised in their earlier complaints.

IV. CONCLUSION

For the foregoing reasons, Defendants respectfully request that this Court deny Plaintiffs' Motion for Leave to File Third Amended Complaint and Jury Demand.

Respectfully submitted,

By: /s/ Mark Biros/FPH
Mark J.Biros
Thomas H. Brock
CASSON & HARKINS
1233 20th Street, N.W., Suite 800
Washington, D.C. 20036-2396
(202) 778-1100

Dated: November 15, 1991

By: /s/ [illegible]
for Dennis L. Kennedy
Louis E. Garfinkel
LIONEL SAWYER & COLLINS
300 So. Fourth St., Suite 1700
Las Vegas, Nevada 89101
(702) 383-8888

Attorneys for Defendants
Humana Inc. and Humana
Health Insurance of Nevada, Inc.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of Defendants' Memorandum of Points and Authorities in Opposition to Plaintiffs' Motion for Leave to File Third Amended Complaint was deposited in the U.S. mail at Las Vegas, Nevada, enclosed in a sealed envelope upon which first-class postage was fully prepaid, addressed to:

Stanley M. Chesley, Esq.
Wait, Schneider, Bayless
& Chesley Co., L.P.A.
1515 Central Trust Tower
Fourth and Vine Streets
Cincinnati, Ohio 45202

John J. Cummings, III, Esq.
Cummings, Cummings & Dudenhefer
416 Gravier Street
New Orleans, Louisiana 70130

Wendell H. Gautheir, Esq.
Gautheir and Murphy
3500 N. Hullen street
Metairie, Louisiana 70002

W. B. Markovits, Esq.
Markovits & Greiwe
119 E. Court Street, Suite 500
Cincinnati, Ohio 45202

on this ___ day of _____, 1991.

_____
An employee of
Lionel Sawyer & Collins

RECEIPT OF COPY

Receipt of copy of Defendants' Memorandum of Points and Authorities in Opposition to Plaintiffs' Motion for Leave to File Third Amended Complaint is hereby acknowledged this 15 day of Nov, 1991.

JONES, JONES, CLOSE & BROWN

/s/ J. Randall Jones
J. Randall Jones, Esq.
700 Valley Bank Plaza
300 South Fourth Street
Las Vegas, Nevada 89101-6026

[Letterhead of Casson, Harkins & Greenberg, Washington, D.C.]

September 27, 1991

VIA TELECOPY

J. Randall Jones, Esq.
Jones, Jones, Close & Brown
700 Valley Bank Building
300 South Fourth Street
Las Vegas, Nevada 89101-6026

Re: *Forsyth v. Humana*

Dear Randall:

As promised, enclosed please find a list of persons who should be able to testify concerning the matters raised in the eighty (80) depositions you noticed previously. For convenience, I have noted across from the name of the person categories to which they can respond. Enclosed is a list of the deposition categories referenced below.

Ken Grubb	3, 23
Don Stewart	4, 5, 12, 15, 16, 17, 24, 25, 34
John Egermayer	4
Gary Mann	5, 15, 16, 17, 35, 36, 37
David Wills	6
Jerry McClellan	9, 11, 29, 31
Bruce Scott	1, 2, 4, 5, 8, 12, 13, 33
Jerry Miller	15, 16, 35, 36
Gary Metcalf	25, 35, 36, 37
Glenn Bossmeyer	26
Joan Kroger	10, 30
Darlene Curlee	10, 30

Lori Wojtowicz	31
George Atkins	34
John Grady	18, 38
Dee Jordan	18, 38
Rich Robinson	3, 23
Alice Newton	10, 30
Helen Faith	1, 2, 4, 5, 8, 12
Carol Stitt	4, 5, 12, 14, 15, 16, 17
Sharon Hicks	6
Larry Carlton	5, 15, 16, 17
Sam Hazen	4, 5, 12, 14, 15, 16, 17
Carol Pullin	19, 20
D. Jones	28
Maureen Cash	19, 20
James Bohanon	24, 25, 35, 36, 37
W. Larry Cash	1, 2, 4, 5, 8, 12, 21, 22, 24, 25, 26, 28, 32

Please call me to work out the schedule.

Very truly yours,

/s/ Mark J. Biros
Mark J. Biros

cc: John Andris
Dennis Kennedy
Louis Garfinkel

[wpj:00480ltr7]

CUSTODIAN OF RECORDS DEPOSITION CATEGORIES

1. HHIN's failure to reduce co-payments or share discounts given by Humana Inc. for per diem hospital charges
2. HHIN retention of co-payment refunds negotiated with Humana Inc.
3. Names of premium payors and what premiums were paid [HIN's premiums]
4. Discussions by HHS, HHIN, GHI to increase or maintain number of patients utilizing HHS
5. Decision $125 per diem or other discount comparable to one between HI and HHIN would/would not be provided/offered to other group health insurers for patients treated at HHS
6. AB 289 required HHI to pass along difference between #125 per diem and rate charged others
7. Monopolizing major for-profit acute-care facilities in Clark County, NV by HI, HHIN, GHI
8. Decision to charge different co-payment for obtaining services from any non-Humana for-profit acute-care hospitals than for doing so from HHS
9. Policies or standard of review for evaluating and paying claims from patients who were treated at non-Humana for-profit acute-care hospitals, as opposed to HS
10. All records of HI, GHI, HHIN re directors meeting from 1/84 til present re HHS $125 per diem discount or NV operations of Defendants
11. Policies for claims review of patients of HHS who were insured by HHIN during 1984-1988

12. Monies rebated between HI and HHIN from 1984 til present based on $125 per diem for in-patient hospitalization and any other rebate 40% or greater of actual billed charges
13. Transactions posted to general ledger accounts in support of "policy claims liability account" and contributed surplus account for 1983-1988
14. Meetings in 1989 between State of Nevada Governor and Humana employees
15. Records re HHS hospital charges for services for 1984-1988 to charges for same or similar services at for-profit acute-care facilities
16. 1983-1988 records re comparative studies of HHS with other hospitals as to rates charged, percentage returned on investment, net operating income
17. HHS's profit margins whether gross or not, from 1985 to present as compared with other acute-care facilities
18. Any correspondence during 1984-1988 with persons insured by HICN that explained any benefits or limitations of their insurance policies
19. Records that refer or relate to Mutual Administrators
20. Records received from Mutual Administrators per termination of contract between Mutual Administrators and HICN

PERSON MOST KNOWLEDGEABLE DEPOSITION CATEGORIES

21. HHIN's failure to reduce co-payments or share discounts given by Humana Inc. for per diem hospital charges
22. HHIN retention of co-payment refunds negotiated with Humana Inc.
23. Names of premium payors and what premiums were paid [HIN's premiums]
24. Discussions by HHS, HHIN, GHI to increase or maintain number of patients utilizing HHS
25. Decision $125 per diem or other discount comparable to one between HI and HHIN would/would not be provided/offered to other group health insurers for patients treated at HHS
26. AB 289 required HHI to pass along difference between $125 per diem and rate charged others
27. Monopolizing major for-profit acute-care facilities in Clark County, NV by HI, HHIN, GHI
28. Decision to charge different co-payment for obtaining services from any non-Humana for-profit acute-care hospitals than for doing so from HHS
29. Policies or standard of review for evaluating and paying claims from patients who were treated at non-Humana for-profit acute-care hospitals, as opposed to HS
30. All records of HI, GHI, HHIN re directors meeting from 1/84 til present re HHS $125 per diem discount or NV operations of Defendants
31. Policies for claims review of patients of HHS who were insured by HHIN during 1984-1988

32. Monies rebated between HI and HHIN from 1984 til present based on $125 per diem for in-patient hospitalization and any other rebate 40% or greater of actual billed charges

33. Transactions posted to general ledger accounts in support of "policy claims liability account" and contributed surplus account for 1983-1988

34. Meetings in 1989 between State of Nevada Governor and Humana employees

35. Records re HHS hospital charges for services for 1984-1988 to charges for same or similar services at for-profit acute-care facilities

36. 1983-1988 records re comparative studies of HHS with other hospitals as to rates charged, percentage returned on investment, net operating income

37. HHS's profit margins whether gross or not, from 1985 to present as compared with other acute-care facilities

38. Any correspondence during 1984-1988 with persons insured by HICN that explained any benefits or limitations of their insurance policies

[seb:00480chart]

J. RANDALL JONES, ESQ.
WILL KEMP, ESQ.
JONES, JONES, CLOSE
& BROWN, CHARTERED
700 Valley Bank Plaza
300 South Fourth Street
Las Vegas, NV 89101-6026
Telephone: (702) 385-4202

STANLEY M. CHESLEY, ESQ.
WAITE, SCHNEIDER, BAYLESS &
CHESLEY CO., L.P.A.
1515 Central Trust Tower
Fourth and Vine Streets
Cincinnati, OH 45202

JOHN L. CUMMINGS III, ESQ.
CUMMINGS, CUMMINGS & DUDENHEFER
416 Gravier Street
New Orleans, LA 70130

WENDELL GAUTHIER, ESQ.
GAUTHIER & MURPHY
3500 North Hullen Street
Metairie, LA 70002

ATTORNEYS FOR PLAINTIFFS

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO. CV-S-89-249-PMP (L.R.L.)

MARY FORSYTH; MARRIETTA CADE; WILLIE ANDREWS; MARY LOU BUEHLER; HELEN STAVES; RANDOLPH BRATTON; and SEARLE AUTO GLASS, INC., doing business as BEST GLASS COMPANY,

Plaintiffs,

vs.

HUMANA, INC., a Delaware corporation; HUMANA HEALTH INSURANCE OF NEVADA, INC., a Nevada corporation; and DOES I through X, inclusive,

Defendants.

PLAINTIFFS' REPLY TO DEFENDANTS' OPPOSITION TO MOTION FOR LEAVE TO FILE THIRD AMENDED COMPLAINT AND JURY DEMAND

Plaintiffs, by and through their counsel of record, Jones, Jones, Close & Brown, Chartered, hereby file this Reply to Defendants' Opposition to Plaintiffs' Motion for Leave to File Third Amended Complaint and Jury Demand. This Reply is based on pleadings and papers on file with the Court and the points and authorities set forth herein.

POINTS AND AUTHORITIES

I

STATEMENT OF THE CASE

On March 29, 1989, Plaintiffs filed their initial Complaint in this matter. On April 28, 1989, Defendants filed a Motion to Dismiss that Complaint. On September 27, 1989, this Court entered an Order effectively denying that Motion to Dismiss. On October 27, 1989, Plaintiffs filed an Amended Complaint in response to the rulings in that Order. On January 18, 1990, Defendants filed a Second Motion to Dismiss. On July 9, 1991, this Court entered an Order effectively denying that Second Motion to Dismiss. In that Order the Court granted Plaintiffs leave to file a Second Amended Complaint, and on August 12, 1991, Plaintiffs filed their Second Amended Complaint. On September 4, 1991, Defendants filed their first Answer.

On October 31, 1991, Plaintiffs filed their Motion to File Third Amended Complaint and Jury Demand ("Motion") (Exhibit 1). On November 15, 1991, Defendants filed their Opposition ("Opposition") (Exhibit 2).

II

INTRODUCTION

Five compelling reasons argue for granting the proposed Third Amended Complaint:

1. The overwhelming weight of authority has long since established that leave to amend is granted with extreme liberality. In opposing Plaintiffs' Motion, Defendants have cited merely a few scattered decisions where courts denied leave to amend only after dismissing the plaintiffs' claims or issuing summary judgment against them.

2. Defendants offered no grounds for assuming prejudice to themselves. Any delay that Plaintiffs' proposed Amendment might occasion is simply inconsequential by comparison with the enormous delays that Defendants themselves have brought to this matter.

3. Defendants are not even in a position to argue, on behalf of Cherry and Cash, that Plaintiffs' proposed Third Amended Complaint might prejudice those individuals—especially when Cherry and Cash themselves have raised no objections. Beyond that, the objections Defendants raise are altogether meritless. Cherry and Cash are not only appropriate individuals for Plaintiffs to name; they are the *most* appropriate individuals, according to information provided by Defendants themselves—and only *after* Plaintiffs filed their Second Amended Complaint. Moreover, the proposed amendment does not in fact prejudice Cherry and Cash. To the contrary, its timing may well benefit them, allowing Cherry and Cash to save thousands of dollars by

drawing on the litigation and discovery efforts that Defendants have already completed.

4. Defendants have offered no grounds for this Court to ignore the Ninth Circuit decision in *Reddy v. Litton Indus., Inc.*, 912 F.2d 291 (9th Cir. 1990), *cert. denied*, 60 U.S.L.W. 3057 (October 15, 1991), a decision issued well *after* Plaintiffs filed their first Amended Complaint and one that the United States Supreme Court refused to overturn only *after* Plaintiffs filed their Second Amended Complaint.

5. Nor have Defendants even attempted to offer any grounds for this Court to deny Plaintiffs an opportunity to recover for Defendants' violations of 18 U.S.C. § 1503—once more, violations that occurred or that Plaintiffs discovered only *after* filing their Second Amended Complaint.

Accordingly the path is clear for this Court to grant Plaintiffs' Motion; and, in the interests of both justice and judicial economy, it may do so without reservation.

III

ARGUMENT

1. Leave to Amend is Granted with *Extreme Liberality*

The most compelling observation on granting leave to amend a complaint that has issued from the Ninth Circuit appeared in *United States v. Webb*, 655 F.2d 977 (9th Cir. 1981):

> In exercising this discretion, a court must be guided by the underlying purpose of Rule 15—to facilitate decision on the merits, rather than on the pleadings or technicalities. Accordingly, Rule 15's policy of favoring amendments to pleadings should be applied with "*extreme liberality*."

Id. at 979 (emphasis added) (citations omitted).

Defendants have cited a few isolated instances where courts denied leave to amend, plucking from each of those decisions a few abstract principles as if they were ripe plums. Yet Defendants have otherwise disregarded the meat of those decisions, the specific situations that prompted the courts to deny leave to amend. Most significantly, *every one of the decisions* cited and relied on by Defendants *followed a dismissal of the complaint or a summary judgment against the plaintiff*. Defendants have not cited *even one decision* where a court denied leave to amend after refusing to dismiss the action—or, for that matter, after *twice* refusing to dismiss the action, as in the present instance.

In the very first decision cited by Defendants, *Foman v. Davis*, 371 U.S. 178 (1962), the Court in fact *granted* leave to amend. That is the reason Plaintiffs themselves cited *Foman* in their Motion, at 2.

Defendants have then cited *Fidelity Financial Corp. v. Federal Home Loan Bank of San Francisco*, 792 F.2d 1432 (9th Cir. 1986), *cert. denied*, 479 U.S. 1064 (1987), for the proposition that "the district court's discretion to deny leave to amend is particularly broad where the court has already given the plaintiff an opportunity to amend his complaint," Opposition at 6, *citing Fidelity*, 792 F.2d at 1438. Yet in *Fidelity* the Ninth Circuit refused to grant leave to amend when the court below had already issued summary judgment for the Defendant, and because the plaintiff "was simply restating its prior claims under new labels." *Fidelity*, 792 F.2d at 1438. The present litigation contrasts sharply with that situation. Here the Court has not granted summary judgment for Defendants; to the contrary, it has recently *denied* almost all of defendants' protracted efforts to dismiss Plaintiffs' claims. Here Plaintiffs' Motion is not even arguably an effort to resurrect meritless claims in a new guise.

The same situation that obtained in *Fidelity* arose in *Jackson v. Bank of Hawaii*, 902 F.2d 1385 (9th Cir. 1990), only more so. In *Jackson* the court below had already dismissed all save one of the plaintiffs' claims. The court then heard a motion for summary judgment on that remaining claim and a motion for leave to amend. As in *Fidelity*, the court granted summary judgment and denied the motion to amend.

Moreover, in *Jackson* the plaintiffs had alleged RICO violations only of 18 U.S.C. § 1962(a) and (b). On appeal, the Ninth Circuit ruled that "these additional claims advance different legal theories and require proof of different facts." In the present matter, by contrast, Plaintiffs have sought merely to add *conspiracy* involving the 18 U.S.C. § 1962(a) and (c) violations that Plaintiffs have long since alleged. Any additional facts necessary to establish that conspiracy are altogether minimal.

Similarly, Plaintiffs' allegations implicating the Nevada RICO statutes are essentially coextensive with Plaintiffs' federal RICO allegations. The clearest evidence of this lies in the proposed Third Amended Complaint itself, wherein the first 11 paragraphs of the Nevada RICO allegations, apart from the specific statutes cited, are absolutely identical to the first 11 paragraphs of the federal RICO allegations. The same is true of the 23 paragraphs numbered 231 - 253 in the Nevada RICO portion; those are absolutely identical to the 23 paragraphs numbered 174 - 196 in the federal RICO portion.

Defendants then cite *Ascon Properties, Inc. v. Mobil Oil Co.*, 866 F.2d 802 (9th Cir. 1989), noting that the court denied leave to file a third amended complaint. What Defendants neglect to report is that the court in that matter had earlier dismissed *both* the first amended complaint *and* the second amended complaint. Clearly the court had lost patience with the plaintiff's efforts to fashion a valid claim for relief.

Similarly, in *McGlinchy v. Shell Chemical Co.*, 845 F.2d 802 (9th Cir. 1988), the court had granted summary judgment against the plaintiffs, and in *Allen v. City of Beverly Hills*, 911 F.2d 367 (9th Cir. 1990), the court had dismissed the complaint. The situation in *Allen* was especially dissimilar to that in the present litigation. In *Allen* the court refused to grant leave on grounds of futility, i.e., that the plaintiff could not possibly identify any grounds for recovery. Here, by contrast, Plaintiffs' initial pleadings have already handily survived two hard-fought battles over dismissal, and this Court has even *reinstated* one of Plaintiffs' claims that it had earlier disallowed. *See* Order of July 9, 1991, at 23-25.

Defendants have strained and failed to locate even one decision where a court denied leave to amend in a situation comparable to the one here. Plaintiffs' proposed Third Amended Complaint is a perfectly reasonable measure, designed to reduce some of the technical deficiencies arguably present in its predecessors, and to set forth in one final, comprehensive form all of the claims that Plaintiffs believe should be joined before this Court in the present litigation. For reasons of judicial economy and in the interests of justice, this Court ought to grant Plaintiffs' Motion.

2. The Proposed Third Amended Complaint is a Natural Evolutionary Development in This Litigation

A broader perspective on the course of this litigation may be in order. On October 27, 1989, after this Court had denied Defendants' first Motion to Dismiss, Plaintiffs filed their first Amended Complaint. On November 17, 1989, Plaintiffs stipulated to allow Defendants an additional 15 days to file their Answer by December 12, 1989. On December 13, 1989, Plaintiffs stipulated to allow Defend-

ants an additional five weeks to file their Answer by January 18, 1990. Finally, on January 18, 1990, more than two and a half months after Plaintiffs had filed their first Amended Compliant, Defendants filed, instead of an Answer, a Second Motion to Dismiss.

For almost eighteen months thereafter, Plaintiffs and Defendants disputed the issues in that Second Motion to Dismiss. By the time this Court denied that Motion, nearly two and a half years had passed in this litigation and *Defendants had not yet even filed an Answer*.

This Court held a hearing on that Second Motion to Dismiss on September 25, 1990, scarcely one month after the decision in *Reddy*, and *Reddy* had not yet come to the attention of Plaintiffs at the time of that hearing. Defendants now contend that Plaintiffs were obligated to amend their allegations after that hearing, while this Court was weighing the Second Motion to Dismiss, rather than awaiting the Court's ruling on that Motion. After the interminable delays caused by Defendants' two Motions to Dismiss, however, Plaintiffs wanted to resolve those issues and finally obtain an Answer.

By the time this Court denied that Motion and granted Plaintiffs leave to file a Second Amended Complaint, Plaintiffs were considering a variety of amendments that have now surfaced in their proposed Third Amended Complaint. Plaintiffs regarded the Second Amended Complaint as merely an interim effort, filed principally to cure a defect in the First Amended Complaint and to compel an Answer from Defendants.

Plaintiffs then enlisted the assistance of nine attorneys and numerous experts from across the United States to draft a comprehensive Third Amended Complaint that might withstand any prospective scrutiny, in this Court or on any level of appeal. That process required rather more than the one

month available to Plaintiffs for filing their Second Amended Complaint. Plaintiffs nonetheless managed to complete the proposed Third Amended Complaint in slightly more than three months.

Defendants contend that they "would be prejudiced because the Third Amended Complaint would effectively nullify Defendants' efforts over the past two and a half years to narrow and refine the scope of Plaintiffs' pleadings," Opposition at 2; *see also id.* at 14. Yet in many respects the proposed Third Amended Complaint is a direct outgrowth of Defendants' efforts "to narrow and refine" the issues in this litigation, to correct areas that might otherwise remain problematic. That is true, for instance, of Plaintiffs' revisions concerning the RICO "person" and the RICO "enterprise." It is ironic that Defendants now oppose those and other modifications and clarifications that were prompted in large measure by Defendants' own efforts.

Defendants additionally contend that they "have already propounded extensive written discovery tailored to ascertain the basis for particular allegations in the Second Amended Complaint. This discovery would be rendered moot by the Third Amended Complaint," Opposition at 14-15. Defendants' attempts to portray the proposed Third Amended Complaint as a complete departure from its predecessors are grossly misplaced. Countless paragraphs in the Second Amended Complaint have survived intact in this newer version, including many that formed the bases for Defendants' written discovery. For that reason Plaintiffs have already expended hundreds of hours in researching and preparing their responses to Defendants' discovery requests, once more enlisting the assistance of at least six attorneys and several experts — all at a cost to Plaintiffs of many thousands of dollars — and Plaintiffs have every intention of delivering those responses to Defendants by or before their present due date of December 2, 1991. If Plaintiffs believed

those responses might be "rendered moot" by the proposed Third Amended Complaint, then Plaintiffs would have long since filed a motion to stay the deadline for filing those responses, pending this Court's ruling on Plaintiffs' Motion for Leave to Amend.

The specter that Defendants have raised of "requir[ing] Defendants to return their defense to square one," Opposition at 5, is not only a chimera; it represents a monumental hypocrisy. By far the greatest discovery burden during the course of this litigation has fallen and continues to fall on Plaintiffs, not on Defendants. It is Plaintiffs, not Defendants, who have every reason to want this matter concluded promptly. It is Plaintiffs, not Defendants, who have repeatedly sought to move this matter along to a final resolution. Conversely, it is Defendants, not Plaintiffs, who have pursued an ongoing strategy of endless delay and dilatory tactics, and whose discovery abuses have even prompted this Court to impose monetary sanctions. When the parties filed a Joint Discovery Conference Report this past September 18, it was Plaintiffs who requested an end to discovery within six months, while it was Defendants who requested an additional year. The Court then set a discovery deadline of January 31, 1992, and Plaintiffs have no intention of attempting to pursue discovery beyond that date. Any efforts at additional delay in this litigation will emanate from Defendants, not from Plaintiffs. Moreover, given that Defendants had initially sought an additional twelve months for discovery, their ardent defense of the four-month deadline this Court imposed reveals itself as nothing more than opportunistic posturing.

Defendants' position in this regard, moreover, is markedly ambivalent. At the same time that Defendants contemplate "return[ing] their defense to square one," they concede that "Plaintiffs do not allege any new facts in their Third Amended Complaint in their attempt to state a claim against

Cherry and Cash." Opposition at 12. Yet almost the entirety of the ERISA and RICO claims in the proposed Third Amended Complaint set forth parallel and identical allegations against Humana, Humana Insurance, Wendell Cherry, and William Larry Cash. If Plaintiffs have not alleged any new facts regarding Cherry and Cash, then Plaintiffs have not alleged any new facts regarding Humana and Humana Insurance. And if Plaintiffs have not alleged any new facts regarding Humana and Humana Insurance, then Defendants are scarcely compelled to "return their defense to square one."

In truth, the *substance* of Plaintiffs' proposed Third Amended Complaint differs from that of its predecessor only in its new allegations involving 18 U.S.C. § 1503.[1] In essentially all other respects the proposed Third Amended Complaint merely incorporates technical improvements. It vitiates no prior discovery, nor requires any new discovery, other than with respect to those § 1503 allegations.

3. Plaintiffs' Claims Against Wendell Cherry and William Larry Cash Are Proper

a. Humana and Humana Insurance Have No Standing to Argue Prejudice Against Cherry and Cash

When Plaintiffs filed their Motion to File the proposed Third Amended Complaint, they served a copy of that Motion and the proposed Complaint on both the administra-

---

[1] Defendants lament that "even after a detailed comparison of the allegations of the pending Second Amended Complaint and the claims set forth in the proposed Third Amended Complaint, it is not clear whether Plaintiffs intend to change the substance of their claims under ERISA and the antitrust laws. Before leave is granted, Plaintiffs should be required to answer these questions." Opposition at 13-14. Plaintiffs believe the proposed amendments speak for themselves and require no collateral analysis, interpretation, or amplification by Plaintiffs. In the interest of moving these matters along, however, Plaintiffs respond to Defendants' questions as follows: No.

tor of the estate of Wendell Cherry and on William Larry Cash *personally* on November 4, 1991. Hence both of those prospective co-Defendants have had an opportunity to respond to that Motion by filing opposing amici briefs with this Court. They have not done so. This Court has not heard one word from Cherry and Cash in opposition to the proposed Complaint. The only opposition to that Complaint has come from the present Defendants, Humana and Human Insurance. And insofar as Defendants' objections involve alleged prejudice only to Cherry and Cash, Defendants simply have no standing to raise those objections.

Moreover, Defendants contend only that "Cherry and Cash will clearly be prejudiced if they are joined as parties," Opposition at 10, without ever alleging that Defendants themselves — the present Defendants, consisting of Human and Humana Insurance — will be prejudiced in any manner. Every argument in Defendants' Opposition concerning prejudice to the present Defendants involves amendments *other* than the addition of Cherry and Cash as co-Defendants.

b. Cherry and Cash Are Appropriate Candidates for Plaintiffs' Proposed Amendment

As executive officers and directors of Humana and Humana Insurance, Cherry and Cash had a close and even intimate relationship with the present Defendants. One authority has observed that "plaintiffs have been allowed . . . to add or substitute parties where there is an extremely close corporate or other relationship between the original and added defendant, and accrues no prejudice to the new party," 3 James W. Moore, Richard D. Freer, *Moore's Federal Practice* ¶ 15.05[5] (2d ed. 1991). Courts have so allowed in the first circuit (*see, e.g., Ayala Serrano v. Collazo Torres*, 650 F. Supp. 722 (D.P.R. 1986); the second circuit (*see, e.g., Holiday Publishing Co. v. Gregg*,

330 F. Supp. 1326 (S.D.N.Y. 1971); the third circuit (*see, e.g., Gram v. May*, 41 F.R.D. 52 (E.D. Pa. 1966); the fifth circuit (*see, e.g., Wedgwood v. Fiberboard Corp.*, 706 F.2d 541 (5th Cir. 1983); the seventh circuit (*see, e.g., Clark v. Universal Builders, Inc.*, 501 F.2d 324 (7th Cir.), *cert. denied*, 419 U.S. 1070 (1974); and the tenth circuit (*see, e.g., United States for use of Construction Specialties Co. v. Travelers Ins. Co.*, 40 F.R.D. 316 (D. Colo. 1966). The only contrary decisions cited in *Moore* occurred in Pennsylvania, and the most recent of those was in 1962. In *Ayala Serrano*, the court expressly ruled that "where the proposed party's interests are sufficiently aligned with those of the original defendant, the latter is presumed to give notice of suit to the former." *Ayala Serrano*, 650 F.Supp. at 726 (citations omitted).

c. New Facts Have Arisen Concerning the Involvement of Cherry and Cash

As noted *supra*, one of Defendants' objections is that

> Plaintiffs do not allege any new facts in their Third Amended Complaint in their attempt to state a claim against Cherry and Cash. Instead, the Third Amended Complaint realleges the purported misconduct heretofore attributed to the corporate Defendants and merely alleges that the individual Defendants are liable in their official capacities. Such generic allegations against Humana's officers and directors could have been asserted in Plaintiffs' original complaint over two and a half years ago. Plaintiffs offer no explanation or justification as to why Cherry or Cash were not joined in any of their three earlier complaints or why these individuals should be joined at this late date.

Opposition at 12-13. Plaintiffs believe no "explanation or justification" is legally required to name new parties who caused harm to Plaintiffs. Plaintiffs additionally observe that

the decisions Defendants cite for the proposition that "new facts" are necessary, *see id.* at 12, do not involve the addition of new *parties*, only of new *claims*.

Beyond that, however, Defendants' argument is ill-founded. Although Plaintiffs have not alleged "new facts" regarding the *violations* that Defendants committed, Plaintiffs have, in reality, alleged "new facts" regarding the specific *involvements* of Cherry and Cash in committing those violations. Many of those new facts, moreover, have come to light only as Defendants grudgingly responded to Plaintiffs' discovery requests, and some of them only quite recently.

Perhaps the most graphic demonstration of those new facts arose on September 27, 1991, after Plaintiffs had filed their Second Amended Complaint. Plaintiffs had sought to depose the custodians of records and persons most knowledgeable at Humana and Humana Insurance with respect to numerous issues. Defendants then informed Plaintiffs that in some instances the same individual might qualify as the custodian or person most knowledgeable for more than one issue, and accordingly Defendants prepared a list identifying those individuals. That list appears as Exhibit 3.

In that list, the individual that counsel for Defendants identified as the custodian and person most knowledgeble regarding far more issues than anyone else was William Larry Cash. *Counsel for Defendants identified Cash as the custodian and person most knowledgeable regarding the following*

> —Why Humana Insurance failed to reduce the copayments required of its insureds or otherwise to pass along or share with its insureds the discount, rebate, or refund it was given by Humana for per diem hospital charges;

> —Why Humana Insurance retained copayment refunds that it negotiated with Humana;
>
> —Efforts by Humana-Sunrise, Humana Insurance, or Group Health Insurance, Inc. to maintain or increase the number of patients using Humana-Sunrise;
>
> —Any decision that the $125 per diem or other discount comparable to the one between Humana and Humana Insurance would or would not be provided or offered to any other group health insurers for patients who were treated at Humana-Sunrise;
>
> —Any consideration, discussion, or research by Defendants as to whether AB 289 required Humana Insurance to pass along to or share with insureds, in the form of premium refunds, rebates, or reductions, the difference between the $125 per diem and the rate charged others;
>
> —The decision to charge a co-payment for obtaining services from any non-Humana for-profit acute-care hospitals different from the co-payment for obtaining services from Humana-Sunrise;
>
> —Monies rebated between Humana and Humana Insurance, including without limitation rebates, refunds, or other monetary transfers based on a $125 per diem for in-patient hospitalization, and any other rebate, refund, or discount from Humana-Sunrise to Humana Insurance that was 40% or greater of actual billed charges.

Consequently, by Defendants' own admissions, William Larry Cash was the sole living individual associated with Humana and Humana Insurance who was most intimately and directly involved in the ERISA and RICO violations that Defendants committed. Those "new facts" came to light on September 27, 1991, *less than two months ago*. It was those

"new facts," among others, that prompted Plaintiffs to identify William Larry Cash as one of the two key individuals whose acts had injured Plaintiffs.

d. Cherry and Cash Will Not Be Prejudiced

Defendants contend that "[Cherry and Cash] were never placed on notice of any potential individual liability when Plaintiffs filed their earlier pleadings. . . . [T]he action has taken a shape over which [Cherry and Cash] had no control." Opposition at 10.

Defendants have not specified how or in what manner Cherry and Cash might be prejudiced by this amendment. Plaintiffs have merely asserted, without more, that "Cherry and Cash will clearly be prejudiced." *Id.* This Court ought to resist Defendants' invitation to assume some abstract prejudice in the absence of any evidence or argument indicating what prejudice, if any, might accrue.

Defendants have not indicated, for instance, and Plaintiffs cannot imagine, precisely how the "shape" of this litigation might have changed if Plaintiffs had named Cherry and Cash as individual defendants earlier. Every act that Plaintiffs have attributed to Cherry and Cash, Plaintiffs have attributed to the present Defendants as well. In the process of defending Humana and Humana Insurance against those allegations, opposing counsel has effectively defended Cherry and Cash against them as well.

Moreover, Defendants themselves have consistently adopted to position that this litigation is not essentially a dispute over facts at all; it is merely a series of disputes over legal interpretations and applications. Defendants are thereby hoist by their own petards. If this litigation involves merely legal interpretations and not facts, then adding Cherry and Jones as co-Defendants will not affect those disputes in the slightest.

e. Any Additional Delay Is Speculative or Minimal

Defendants contend that "[i]t is manifestly unjust for these individuals now to be joined in litigation already two and a half years old." Opposition at 10. The reason this litigation is "already two and a half years old," however, is that Defendants themselves have managed to delay and prolong this litigation for that length of time, even resorting to stratagems that were sanctioned by this Court. If any prejudice has accrued to Cherry and Cash as a consequence, it is not because Plaintiffs failed to name Cherry and Cash initially; it is because Defendants stalled for two and half years before filing an Answer, stalled in responding to almost every discovery request Plaintiffs issued,[2] stalled by interposing endless and groundless objections to those discovery requests, stalled by filing one meritless motion after another, and otherwise incessantly protracted the course of this litigation.

Similarly, Defendants assert that granting leave to amend "will significantly prolong this action. For example, Cherry and Cash likely will move to dismiss the Third Amended Complaint." Opposition at 11. The specter of an additional Motion to Dismiss is little more than an idle fantasy conjured by counsel for Defendants. Defendants' counsel do not represent the estate of Wendell Cherry, nor do they represent William Larry Cash. In fact, they are almost certainly precluded from representing those individuals due to inher-

---

[2] As only the most recent example of Defendants' delaying tactics, three days before Plaintiffs filed this Reply, Defendants served on Plaintiffs their Third Supplemental Response to Plaintiffs' First Request for Production of Documents. That Third Supplemental Response consists of several hundred pages of documents in response to Plaintiffs' Requests Nos. 5, 12, 18, 33, and 37. Plaintiffs had initially requested those documents on November 8, 1989, *over two years ago*. Moreover, this Court ordered Defendants to produce their responses to Requests Nos. 12 and 37 on September 27, 1990—*fourteen months ago*.

ent and pervasive conflicts of interest. Hence they are in no position to fashion imaginary scenarios regarding the litigation strategies that counsel for those two individuals may adopt. More important, those imaginary scenarios are scarcely grounds for denying Plaintiffs the opportunity to pursue valid claims against Cherry and Cash.

Once Plaintiffs have served the Third Amended Complaint, then Cherry and Cash may, of course, file a Motion to Dismiss if they believe one is truly warranted. Most of the legal issues in this litigation, however, have already been ruled on by this Court in response to the voluminous and comprehensive Motions to Dismiss that Defendants have previously filed. Accordingly, any Motion to Dismiss that Cherry and Cash might file would be minimal, and any delay it might occasion would be minimal as well.[3]

The same is true of discovery efforts. A great amount of discovery remains to be completed in this litigation, and Cherry and Cash can readily participate. Plaintiffs, whose discovery requirements are far greater than those of Defendants, have every intention of completing their discovery within the present deadline. Cherry and Cash can certainly do so as well.

Moreover, Plaintiffs assume that Defendants will offer to share with Cherry and Cash the discovery that Defendants have completed to the present; alternatively, Cherry and Cash can readily obtain that discovery from Defendants.

---

[3] The only issue Defendants cite that might arise in a Motion to Dismiss by Cherry and Cash is "whether a properly pled RICO conspiracy under § 1962(d) may consist solely of a corporation, its officers, employees or subsidiaries." Opposition at 11 n.5. Plaintiffs resist the temptation to respond to Defendants' arguments concerning that issue *at this time*, and simply observe that it is the *only* issue Defendants have mentioned.

Consequently, rather than finding themselves at a disadvantage in this litigation, Cherry and Cash may well find they have saved countless thousands of dollars in discovery and litigation costs by drawing on the efforts that Defendants have already pursued. Cherry and Cash will be relieved of arguing the numerous legal and technical issues that Defendants have raised during the first two and a half years of this matter, of arguing the numerous motions that Defendants have filed, of drafting the numerous interrogatories, requests for production, and requests for admissions that Defendants have served on Plaintiffs. In the most practical sense, Cherry and Cash may well find they have benefited enormously from the timing of this amendment.

Defendants' other objections are even more groundless. Defendants argue that "the participation of Cherry and Cash as Defendants is not necessary to permit Plaintiffs to pursue their theories of liability." Opposition at 9. The same is true in countless actions involving multiple defendants, yet Plaintiffs are not aware of any restriction on joinder of defendants in this situation to those whose presence is "necessary." Plaintiffs are entitled to name, or not name, any Defendants that Plaintiffs believe are liable for the damages that Plaintiffs incurred.

Defendants then question whether Plaintiffs are engaging in "an improper attempt to facilitate discovery." *Id.* n.4. Plaintiffs, of course, have *no imaginable reason* to facilitate discovery. After all, Defendants have responded so promptly and so completely to all of Plaintiffs' discovery requests that Plaintiffs found it necessary to file only *four motions to compel and two motions for sanctions*. Defendants, moreover, offer no precedent or reasoning for their assertion that facilitating discovery is "improper" or a bad faith reason to amend a complaint. The three decisions Defendants cite, *see id.*, are altogether silent on that issue. In all three of them, moreover, the Ninth Circuit *allowed* leave to amend.

Defendants then question whether Plaintiffs are engaging in "a litigation strategy designed to exert emotional pressure upon the corporate Defendants through active litigation against the Estate." *Id.* Plaintiffs were not aware that corporations even *had* emotions — especially, Plaintiffs are tempted to add, the monolithic corporate Defendants involved in this litigation. This a shabby conjecture for Defendants to advance.

Finally, Defendants have questioned why Plaintiffs are naming "the recently-deceased president of one corporate Defendant," *id.* at 9. Defendants argue: "Plaintiffs have known of the activities of Cherry at all times during this litigation, and waited until Cherry was deceased to name him as a party." *Id.* at 10. Defendants are imputing to Plaintiffs a prescience appropriate only to Mr. Cherry's personal physicians and, one assumes, the Almighty. In truth, the death of Mr. Cherry had no bearing whatever on Plaintiffs' decision, as is evidenced by Plaintiffs' concurrent decision to name William Larry Cash — who was, at last count, still among the living. Plaintiffs do concur in Defendants' assertion that "[t]his loss of access to a potentially vital witness is clearly prejudicial." *Id.* The prejudice, however, is to *Plaintiffs*, not to Defendants. Defendants had countless opportunities to confer with Mr. Cherry regarding these matters during the past two and a half years. Plaintiffs had no opportunities to do so, and now they never will.

4. The Decision in *Reddy* Offers Ample Grounds for Leave to Amend

Plaintiffs have noted that the decision in *Reddy v. Litton Indus., Inc.*, 912 F.2d 291 (9th Cir. 1990), *cert. denied*, 60 U.S.L.W. 3057 (October 15, 1991), resolved in Plaintiffs' favor an issue that prevented Plaintiffs from alleging RICO violations of 18 U.S.C. § 1962(d) conspiracy to violate 18

U.S.C. § 1962(a). *See* Motion at 3-4.[4] Plaintiffs had already alleged violations of § 1962(a), and regarded an allegation of *conspiracy* to violate § 1962(a) as entirely duplicative in terms of the damages that Plaintiffs might recover.

Even the decision in *Reddy* was of no more than academic interest to Plaintiffs so long as their § 1962(a) allegations remained intact. On July 9, 1991, however, this Court dismissed those § 1962(a) allegations, on the grounds that Plaintiffs had not demonstrated and could not demonstrate injury from Defendants' use or investment of racketeering income.

At that moment the decision in *Reddy* acquired new and immediate significance to this litigation. *Reddy* now offered Plaintiffs an opportunity to preserve their § 1962(a) claims by alleging *conspiracy* to violate that section, pursuant to 18 U.S.C. § 1962(d).

Hence Plaintiffs had no reason to cite *Reddy*, or to allege violations of 18 U.S.C. § 1962(d), prior to this Court's Order of July 9, 1991 — less than four months before Plain-

---

[4] Defendants dispute the holding in *Reddy*, asserting that "[n]o case decided subsequent to *Reddy* supports Plaintiffs' interpretation." Opposition at 7 n.2. That is rather less than surprising, given that the United States Supreme Court denied certiorari in *Reddy* only on October 15, 1991, less than one month before Defendants filed their Opposition.

Defendants then cite three decisions, *Saul v. United States*, 928 F.2d 829 (9th Cir. 1991), *Price v. Hawaii*, 921 F.2d 950 (9th Cir. 1990), and *U.S. Concord, Inc. v. Harris Graphics Corp.*, 757 F. Supp. 1053 (N.D. Cal. 1991). Plaintiffs are at a loss to penetrate Defendants' reasons for those citations. The two decisions from the Ninth Circuit, *Saul* and *Price*, did not involve RICO allegations at all. In the decision from the District Court for the Northern District of California, *U.S. Concord*, the court dismissed RICO claims for reasons having nothing to do with the decision in *Reddy*. In fact, the court's only references to *Reddy* did not even involve the § 1962(d) conspiracy.

tiffs filed their motion for leave to amend. Consequently Defendants' assertion that "Plaintiffs have had nearly sixteen months to advise the Court of the *Reddy* decision, to file an amended complaint with the court, and to seek leave to amend their complaint," Opposition at 7, is misguided at best.

Finally, in one of the very decisions relied on by Defendants, *Sierra Club v. Union Oil of Calif.*, 813 F.2d 1480 (9th Cir. 1987), the Ninth Circuit reversed a denial of leave to amend, holding that "[m]ere delay in proffering an amendment does not justify denying leave to amend." *Id.* at 1493 (citation omitted). "Where a defendant is on notice of the facts contained in an amendment to a complaint, there is no serious prejudice to defendant in allowing the amendment." *Id.* Defendants have not even alleged any prejudice by allowing this aspect of the proposed amendment, and Defendants cannot so allege. They were already on notice as to the facts contained in that amendment.

5. New Facts Have Arisen Concerning Defendants' Obstruction of Justice

During their process of refinement, Plaintiffs discovered evidence of abuses by Defendants that prompted the filing of an entirely new claim for relief, involving obstruction of justice in violation of 18 U.S.C. § 1503. Defendants have attempted to disparage that new claim as "elevating these procedural skirmishes to a substantive criminal offense in this complaint," Opposition at 5 n.1, and as an "attempt to bootstrap discovery disputes into an additional cause of action," *id.* Plaintiffs cannot concede, however, that violations of the Federal Rules of Civil Procedure, the Racketeer Influenced and Corrupt Organizations Act, and a federal criminal statute qualify as mere "procedural skirmishes" or "discovery disputes."[5]

In any event, those allegations are certainly proper for inclusion in the proposed Third Amended Complaint. Defendants have offered no reason, only empty rhetoric, to deny Plaintiffs their opportunity to pursue those claims.

6. Defendants' Other Objections Are Meritless

Defendants contend that Plaintiffs have altered their theories of liability. Defendants cite the portion of Plaintiffs' amended ERISA claims alleging "that Defendants submitted a fraudulent master policy to the Insurance Division of Nevada," Opposition at 17, and assert: "This is a new theory of recovery." *Id.* Defendants have misapprehended that portion of the proposed Third Amended Complaint. Plaintiffs are not pursuing recovery for fraud on the Insurance Division of Nevada, nor have Plaintiffs named the Insurance Division as a new class member. Plaintiffs are merely pursuing, now as before, Defendants' fraud on the Premium-Payor Class. Defendants' submission of the fraudulent master policy to the Insurance Division was simply one aspect of the process whereby Defendants accomplished that fraud.

---

[5] Defendants additionally find "anomalous" that Plaintiffs sought to file under seal a Motion for Partial Default involving those allegations, "presumably to avoid impermissible interference with a pending jury trial ongoing in state court," *id.*, yet Plaintiffs did not file their Motion for Leave under seal as well. This Court ought to bear in mind that it was Plaintiffs, not Defendants, who sought to preserve the integrity of that pending trial. And it was Plaintiffs who concluded that integrity was not significantly threatened by minimal references to those allegations buried in a highly technical, 69-page Complaint that was largely incomprehensible to the media. Plaintiffs, moreover, were correct. No mention of those allegations has yet appeared in any media reports, and the jury in that trial returned with its verdict on the very date that Plaintiffs filed the instant Reply.

Defendants contend that "addition of a state RICO claim and federal RICO conspiracy claims to this class action requires a new class certification procedure pursuant to Fed. R. Civ. P.23(c)(1)." Opposition at 16. That is simply erroneous. *The Nevada RICO Premium-Payor and Co-Payor classes will be identical to the federal RICO Premium-Payor and Co-Payor Classes*. Precisely the same issues of numerosity, commonality, typicality, and adequacy are involved as those in regard to the Federal RICO classes — issues that were completely briefed, argued, and ruled on by this Court in certifying those classes. Hence the Court may readily dispose of those issues in certifying Nevada RICO classes. The same is true of Plaintiffs' amended federal RICO conspiracy claims.[6]

Defendants' only other objections to the Nevada RICO claims in Plaintiffs' proposed Third Amended Complaint are that "[t]his state law claim [sic] could have been asserted in Plaintiffs' original complaint. These amendments amount only to shifts in Plaintiffs' legal theories." Opposition at 17. Plaintiffs have not "shifted" their legal theories at all. Plaintiffs have added Nevada RICO claims that, as already noted *supra*, are largely coextensive with Plaintiffs' federal RICO claims.

---

[6] In the decision cited by Defendants to argue that additional class notices are necessary, *Matarazzo v. Friendly Ice Cream Corp.*, 70 F.R.D. 556 (E.D.N.Y. 1976), the court was concerned, inter alia, with issues of increased liability of the plaintiffs to third parties caused by the addition of a new claim that characterized the plaintiffs as independent contractors instead of franchisees. That situation does not even remotely arise here. Moreover, the court in *Matarazzo* held that if, at trial, the problem was shown to add no new burdens to the plaintiffs, then they might be granted leave to amend.

IV

CONCLUSION

The United States Supreme Court declared in *Foman v. Davis*, 371 U.S. 178 (1962), that

> If the underlying facts or circumstances relied upon by a plaintiff may be a proper subject of relief, he ought to be afforded an opportunity to test his claim on the merits. In the absence of any apparent or declared reason . . . *the leave sought should, as the rules require, be "freely given."*

Id. at 182 (emphasis added). Defendants have simply not offered this Court any compelling reason to deny Plaintiffs an opportunity to resolve all of their claims in this litigation at one time, without the necessity for pursuing them in additional actions or in other courts. The prospects of prejudice that Defendants have alleged are abstract and inchoate, without form or substance. The possibility of delay that Defendants have alleged is minuscule compared to the delays that Defendants themselves have already caused. Hence, in accordance with the intent of Fed. R. Civ. P. 15 and the overwhelming authority of precedent, Plaintiffs urge this Court to grant their Motion for Leave to Amend.

DATED this 25th day of November, 1991.

Respectfully submitted,

JONES, JONES, CLOSE
& BROWN, CHARTERED

By /s/ J. Randall Jones
J. RANDALL JONES, ESQ.
JOHN W. FIELD, ESQ.
300 Valley Bank Plaza
300 South Fourth Street
Las Vegas, Nevada 89101

ATTORNEYS FOR PLAINTIFFS

RECEIPT OF COPY

RECEIPT of a true and correct copy of the attached PLAINTIFFS' REPLY TO DEFENDANTS' OPPOSITION TO MOTION FOR LEAVE TO FILE THIRD AMENDED COMPLAINT AND JURY DEMAND is hereby acknowledged this 25 day of November, 1991.

LIONEL SAWYER & COLLINS
By /s/Louis Garfinkel/DIB
LOUIS E. GARFINKEL, ESQ.
1600 Valley Bank Plaza
300 South Fourth Street
Las Vegas, Nevada 89101

CERTIFICATE OF MAILING

I hereby certify that on the 25th day of November, 1991, the foregoing PLAINTIFFS' REPLY TO DEFENDANTS' OPPOSITION TO MOTION FOR LEAVE TO FILE THIRD AMENDED COMPLAINT AND JURY DEMAND was served on the following by mailing a copy thereof, first class mail, postage prepaid, to:

Mark J. Biros, Esq.
CASSON, HARKINS & LAPALLO
1233 20th Street, N.W., #800
Washington, D.C. 20036

/s/ Jill S. Fletcher
An employee of JONES, JONES, CLOSE & BROWN, CHARTERED

UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CASE NO. CV-S-89-249-PMP (LRL)

MARY FORSYTH, et al.

Plaintiffs,

vs.

HUMANA, INC., et al.,

Defendants.

ORDER

Before the Court is Plaintiffs' Motion for Leave to File Third Amended Complaint and Jury Demand (#490), filed October 31, 1991. Defendants filed their Opposition (#508) on November 15, 1991. On November 18, 1991, Plaintiffs filed a Notice of Errata in Motion to File Third Amended Complaint (#509). On November 25, 1991, Plaintiffs filed their Reply (#512).

Having read and considered the papers before it, the Court finds that Plaintiffs have failed to demonstrate that the proposed additions to the complaint could not have been included in earlier amendments. Plaintiffs have had numerous opportunities to apprise Defendants and this Court of all purported grounds for relief and any additional parties they to bring before the Court.

IT IS THEREFORE ORDERED that Plaintiffs' Motion for Leave to File Third Amended Complaint and Jury Demand (#490) is denied.

DATED: December 5, 1991

/s/ Philip M. Pro
PHILIP M. PRO
United States District Judge